



**EmblemHealth**

**CONSUMER DIRECT EPO/PPO**

**HSA Compatible Plans Available for Employer Groups of 1+**

(The EPO is an In-Network-Only Plan) PLH SGC 997/PLH SGC 1000

Rates Effective 1/1/10-3/31/10

**DOWNSTATE**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$319.99	\$815.97	\$319.99	\$607.98	\$703.97	\$943.96
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$265.90	\$678.05	\$265.90	\$505.22	\$584.99	\$784.42
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$242.09	\$617.33	\$242.09	\$460.00	\$532.60	\$714.18
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$177.55	\$452.73	\$177.55	\$337.31	\$390.57	\$523.73
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$122.67	\$312.82	\$122.67	\$233.08	\$269.88	\$361.88

**PPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
	Par/Non-Par	Par/Non-Par	Par/Non-Par Max		Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$326.70	\$882.12	\$326.70	\$637.08	\$741.63	\$1,040.56
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$335.31	\$855.07	\$335.31	\$637.10	\$737.71	\$989.18
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$235.70	\$636.38	\$235.70	\$459.61	\$535.03	\$750.69
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$245.23	\$625.34	\$245.23	\$465.93	\$539.51	\$723.43

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$204.14	\$520.56
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$141.06	\$359.73

**PPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
	Par/Non-Par	Par/Non-Par	Par/Non-Par Max		Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$281.98	\$719.07

**Preventive Care is covered 100%.**  
*In-Network Routine Physicals, Screenings Immunizations, and Well Baby Care are not subject to deductible, coinsurance, or a copay! All your payments count! Emblem's "Shared Deductible" feature means money you spend counts toward both your In-Network and Out-of-Network deductibles -helping you satisfy your deductibles faster!*

\* All Family levels are 2x the Individual level.

11/23/2009

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**Rates Effective 1/1/10-3/31/10**

**MID-HUDSON**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$289.94	\$739.35	\$289.94	\$550.90	\$637.88	\$855.33
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$240.98	\$614.51	\$240.98	\$457.87	\$530.16	\$710.90
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$219.40	\$559.48	\$219.40	\$416.88	\$482.69	\$647.25
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$160.91	\$410.30	\$160.91	\$305.69	\$353.97	\$474.65
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$111.16	\$283.45	\$111.16	\$211.19	\$244.54	\$327.90

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$301.90	\$815.12	\$301.90	\$588.69	\$685.30	\$961.53
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$309.84	\$790.12	\$309.84	\$588.71	\$681.68	\$914.06
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$217.80	\$588.05	\$217.80	\$424.70	\$494.39	\$693.67
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$226.61	\$577.85	\$226.61	\$430.54	\$498.53	\$668.48

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$185.01	\$471.77
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$127.81	\$325.96

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$260.56	\$664.45

**Preventive Care is covered 100%.**  
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**ALBANY**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$271.89	\$693.30	\$271.89	\$516.58	\$598.15	\$802.06
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$225.96	\$576.20	\$225.96	\$429.33	\$497.12	\$666.60
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$205.73	\$524.61	\$205.73	\$390.88	\$452.62	\$606.90
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$150.88	\$384.73	\$150.88	\$286.67	\$331.92	\$445.06
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$104.23	\$265.79	\$104.23	\$198.04	\$229.31	\$307.48

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$283.09	\$764.33	\$283.09	\$552.01	\$642.60	\$901.61
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$290.52	\$740.88	\$290.52	\$552.03	\$639.19	\$857.07
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$204.23	\$551.40	\$204.23	\$398.23	\$463.58	\$650.43
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$212.48	\$541.84	\$212.48	\$403.72	\$467.45	\$626.81

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$173.46	\$442.37
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$119.85	\$305.66

**Preventive Care is covered 100%.**  
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**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$244.34	\$623.04

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**UTICA/WATERTOWN**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$261.10	\$665.81	\$261.10	\$496.10	\$574.44	\$770.25
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$216.92	\$553.14	\$216.92	\$412.15	\$477.22	\$639.91
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$197.49	\$503.61	\$197.49	\$375.24	\$434.50	\$582.61
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$144.85	\$369.33	\$144.85	\$275.19	\$318.63	\$427.24
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$100.11	\$255.25	\$100.11	\$190.19	\$220.22	\$295.30

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$271.75	\$733.73	\$271.75	\$529.90	\$616.88	\$865.52
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$278.90	\$711.22	\$278.90	\$529.92	\$613.61	\$822.77
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$196.05	\$529.33	\$196.05	\$382.28	\$445.02	\$624.39
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$203.97	\$520.14	\$203.97	\$387.57	\$448.74	\$601.71

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$166.52	\$424.66
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$115.10	\$293.55

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$234.56	\$598.10

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**SYRACUSE**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$261.74	\$667.46	\$261.74	\$497.33	\$575.84	\$772.15
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$217.62	\$554.92	\$217.62	\$413.48	\$478.76	\$641.99
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$198.13	\$505.24	\$198.13	\$376.45	\$435.91	\$584.49
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$145.31	\$370.52	\$145.31	\$276.08	\$319.67	\$428.63
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$100.34	\$255.87	\$100.34	\$190.65	\$220.75	\$296.00

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$272.63	\$736.09	\$272.63	\$531.62	\$618.87	\$868.33
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$279.80	\$713.53	\$279.80	\$531.64	\$615.58	\$825.44
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$196.68	\$531.04	\$196.68	\$383.53	\$446.46	\$626.42
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$204.63	\$521.83	\$204.63	\$388.80	\$450.19	\$603.66

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$167.06	\$426.04
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$115.38	\$294.24

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$235.32	\$600.03

**Preventive Care is covered 100%.**  
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**ROCHESTER**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$253.18	\$645.61	\$253.18	\$481.05	\$557.00	\$746.89
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$210.42	\$536.56	\$210.42	\$399.78	\$462.91	\$620.73
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$191.58	\$488.51	\$191.58	\$363.99	\$421.46	\$565.14
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$140.48	\$358.23	\$140.48	\$266.92	\$309.06	\$414.43
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$97.07	\$247.51	\$97.07	\$184.42	\$213.55	\$286.34

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$263.60	\$711.71	\$263.60	\$514.01	\$598.36	\$839.55
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$270.54	\$689.88	\$270.54	\$514.03	\$595.19	\$798.10
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$190.17	\$513.45	\$190.17	\$370.83	\$431.67	\$605.68
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$197.86	\$504.55	\$197.86	\$375.94	\$435.29	\$583.67

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$161.55	\$411.93
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$111.61	\$284.63

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$227.49	\$580.16

**Preventive Care is covered 100%.**  
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**BUFFALO**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$256.98	\$655.33	\$256.98	\$488.28	\$565.37	\$758.11
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$213.46	\$544.32	\$213.46	\$405.57	\$469.61	\$629.71
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$194.35	\$495.57	\$194.35	\$369.26	\$427.56	\$573.31
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$142.51	\$363.44	\$142.51	\$270.78	\$313.55	\$420.43
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$98.53	\$251.24	\$98.53	\$187.19	\$216.76	\$290.65

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$267.42	\$722.03	\$267.42	\$521.45	\$607.05	\$851.72
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$274.47	\$699.87	\$274.47	\$521.48	\$603.80	\$809.66
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$192.93	\$520.89	\$192.93	\$376.20	\$437.93	\$614.47
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$200.72	\$511.84	\$200.72	\$381.38	\$441.59	\$592.12

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$163.88	\$417.90
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$113.29	\$288.92

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$230.80	\$588.56

\* All Family levels are 2x the Individual level.

11/23/2009

\*\*This plan is not compatible with an HSA account and functions only as a high deductible plan.

**Rates are subject to EmblemHealth and NYS Insurance Department Approval.**

Rate illustrations provided for convenience only and are in no way considered proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

No exceptions, including typographical errors or omissions, will be applied or accepted.

**Preventive Care is covered 100%.**  
*In-Network Routine Physicals, Screenings Immunizations, and Well Baby Care are not subject to deductible, coinsurance, or a copay! All your payments count! Emblem's "Shared Deductible" feature means money you spend counts toward both your In-Network and Out-of-Network deductibles -helping you satisfy your deductibles faster!*



# EmblemHealth

## EPO Employer Groups of 2+

(The EPO is an In-Network-Only Plan) PLH EPO-100A/PLH EPO 100U

Rates Effective 1/1/10-3/31/10

### DOWNSTATE



	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Adults/Depts	Hospital	Skilled Nursing	Amb Surg	ER	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$20/\$0	\$0	\$0	\$0	\$50	P R S	\$528.83	\$1,352.55	\$528.83	\$1,008.16	\$1,163.33	\$1,564.59
2	\$30/\$0	\$0	\$0	\$0	\$50	P R S	\$426.70	\$1,092.17	\$426.70	\$814.13	\$938.62	\$1,263.32
3	\$30/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$397.40	\$1,017.47	\$397.40	\$758.46	\$874.20	\$1,176.91
4	\$30/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$365.21	\$935.38	\$365.21	\$697.33	\$803.36	\$1,081.96
5	\$40/\$0	\$0	\$0	\$0	\$50	P R S	\$392.06	\$1,003.87	\$392.06	\$748.34	\$862.45	\$1,161.17
6	\$40/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$364.15	\$932.63	\$364.15	\$695.27	\$801.02	\$1,078.77
7	\$40/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$332.85	\$852.88	\$332.85	\$635.84	\$732.20	\$986.53

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates			4-Tier Rates			
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.						
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

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State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

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# EmblemHealth

## EPO Employer Groups of 2+

(The EPO is an In-Network-Only Plan) PLH EPO-100A/PLH EPO 100U

Rates Effective 1/1/10-3/31/10

### MID-HUDSON



	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Adults/Depts	Hospital	Skilled Nursing	Amb Surg	ER	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$20/\$0	\$0	\$0	\$0	\$50	P R S	\$510.47	\$1,305.74	\$510.47	\$973.31	\$1,122.98	\$1,510.46
2	\$30/\$0	\$0	\$0	\$0	\$50	P R S	\$406.48	\$1,040.64	\$406.48	\$775.75	\$894.18	\$1,203.70
3	\$30/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$378.94	\$970.41	\$378.94	\$723.42	\$833.62	\$1,122.48
4	\$30/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$348.61	\$893.07	\$348.61	\$665.81	\$766.90	\$1,033.00
5	\$40/\$0	\$0	\$0	\$0	\$50	P R S	\$373.53	\$956.65	\$373.53	\$713.17	\$821.74	\$1,106.53
6	\$40/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$347.28	\$889.64	\$347.28	\$663.25	\$763.97	\$1,029.05
7	\$40/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$317.77	\$814.46	\$317.77	\$607.21	\$699.08	\$942.08

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic						
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

No exceptions, including typographical errors or omissions, will be applied or accepted.



# EmblemHealth

## EPO Employer Groups of 2+

(The EPO is an In-Network-Only Plan) PLH EPO-100A/PLH EPO 100U

Rates Effective 1/1/10-3/31/10

### ALBANY



	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Adults/Depts	Hospital	Skilled Nursing	Amb Surg	ER	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$20/\$0	\$0	\$0	\$0	\$50	P R S	\$451.27	\$1,154.81	\$451.27	\$860.83	\$992.76	\$1,335.79
2	\$30/\$0	\$0	\$0	\$0	\$50	P R S	\$363.09	\$930.03	\$363.09	\$693.32	\$798.79	\$1,075.75
3	\$30/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$338.52	\$867.34	\$338.52	\$646.64	\$744.70	\$1,003.25
4	\$30/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$311.46	\$798.34	\$311.46	\$595.22	\$685.18	\$923.44
5	\$40/\$0	\$0	\$0	\$0	\$50	P R S	\$333.73	\$855.12	\$333.73	\$637.51	\$734.17	\$989.09
6	\$40/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$310.29	\$795.32	\$310.29	\$592.96	\$682.59	\$919.94
7	\$40/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$283.98	\$728.22	\$283.98	\$542.97	\$624.69	\$842.32

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options								2-Tier Rates		4-Tier Rates			
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.						
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

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# EmblemHealth

## EPO Employer Groups of 2+

(The EPO is an In-Network-Only Plan) PLH EPO-100A/PLH EPO 100U

Rates Effective 1/1/10-3/31/10

### UTICA/WATERTOWN



	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Adults/Depts	Hospital	Skilled Nursing	Amb Surg	ER	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$20/\$0	\$0	\$0	\$0	\$50	P R S	\$441.63	\$1,130.25	\$441.63	\$842.54	\$971.58	\$1,307.38
2	\$30/\$0	\$0	\$0	\$0	\$50	P R S	\$355.21	\$909.94	\$355.21	\$678.34	\$781.44	\$1,052.50
3	\$30/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$331.28	\$848.88	\$331.28	\$632.88	\$728.76	\$981.88
4	\$30/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$304.89	\$781.62	\$304.89	\$582.75	\$670.76	\$904.09
5	\$40/\$0	\$0	\$0	\$0	\$50	P R S	\$326.50	\$836.66	\$326.50	\$623.77	\$718.26	\$967.74
6	\$40/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$303.66	\$778.42	\$303.66	\$580.37	\$668.00	\$900.38
7	\$40/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$278.02	\$712.98	\$278.02	\$531.62	\$611.56	\$824.70

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic						
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

No exceptions, including typographical errors or omissions, will be applied or accepted.



# EmblemHealth

## EPO Employer Groups of 2+

(The EPO is an In-Network-Only Plan) PLH EPO-100A/PLH EPO 100U

Rates Effective 1/1/10-3/31/10

### SYRACUSE



	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Adults/Dep's	Hospital	Skilled Nursing	Amb Surg	ER	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$20/\$0	\$0	\$0	\$0	\$50	P R S	\$415.34	\$1,063.20	\$415.34	\$792.56	\$913.72	\$1,229.81
2	\$30/\$0	\$0	\$0	\$0	\$50	P R S	\$335.45	\$859.51	\$335.45	\$640.78	\$737.94	\$994.18
3	\$30/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$312.76	\$801.65	\$312.76	\$597.68	\$688.02	\$927.26
4	\$30/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$287.77	\$737.96	\$287.77	\$550.23	\$633.08	\$853.58
5	\$40/\$0	\$0	\$0	\$0	\$50	P R S	\$306.83	\$786.50	\$306.83	\$586.39	\$674.97	\$909.71
6	\$40/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$285.29	\$731.58	\$285.29	\$545.47	\$627.59	\$846.20
7	\$40/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$261.12	\$669.95	\$261.12	\$499.56	\$574.41	\$774.90

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic						
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

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# EmblemHealth

## EPO Employer Groups of 2+

(The EPO is an In-Network-Only Plan) PLH EPO-100A/PLH EPO 100U

Rates Effective 1/1/10-3/31/10

### ROCHESTER



	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Adults/Dep's	Hospital	Skilled Nursing	Amb Surg	ER	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$20/\$0	\$0	\$0	\$0	\$50	P R S	\$417.43	\$1,068.53	\$417.43	\$796.57	\$918.36	\$1,236.02
2	\$30/\$0	\$0	\$0	\$0	\$50	P R S	\$335.76	\$860.25	\$335.76	\$641.33	\$738.59	\$995.01
3	\$30/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$313.06	\$802.35	\$313.06	\$598.21	\$688.62	\$928.06
4	\$30/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$288.00	\$738.59	\$288.00	\$550.73	\$633.64	\$854.32
5	\$40/\$0	\$0	\$0	\$0	\$50	P R S	\$308.59	\$791.05	\$308.59	\$589.77	\$678.87	\$914.95
6	\$40/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$286.92	\$735.81	\$286.92	\$548.62	\$631.23	\$851.08
7	\$40/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$262.63	\$673.80	\$262.63	\$502.41	\$577.73	\$779.36

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic						
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

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# EmblemHealth

## EPO Employer Groups of 2+

(The EPO is an In-Network-Only Plan) PLH EPO-100A/PLH EPO 100U

Rates Effective 1/1/10-3/31/10

### BUFFALO



	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Adults/Dep's	Hospital	Skilled Nursing	Amb Surg	ER	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$20/\$0	\$0	\$0	\$0	\$50	P R S	\$421.28	\$1,078.33	\$421.28	\$803.88	\$926.78	\$1,247.36
2	\$30/\$0	\$0	\$0	\$0	\$50	P R S	\$338.81	\$868.04	\$338.81	\$647.13	\$745.31	\$1,004.07
3	\$30/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$315.89	\$809.59	\$315.89	\$603.63	\$694.91	\$936.45
4	\$30/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$290.64	\$745.29	\$290.64	\$555.68	\$639.39	\$862.02
5	\$40/\$0	\$0	\$0	\$0	\$50	P R S	\$311.38	\$798.20	\$311.38	\$595.10	\$685.05	\$923.25
6	\$40/\$0	\$500	\$200 day/\$600 Max	\$250	\$100	P R S	\$289.54	\$742.46	\$289.54	\$553.58	\$636.95	\$858.79
7	\$40/\$0	\$1,000	\$200 day/\$600 Max	\$750	\$100	O P R S	\$265.00	\$679.90	\$265.00	\$506.97	\$582.97	\$786.39

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic						
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

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State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

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# EmblemHealth EPO IN-BALANCE

Employer Groups of 2+

(The EPO is an In-Network-Only Plan) PLH EPO-995/PLH EPO 994C

Rates Effective 1/1/10-3/31/10

## DOWNSTATE



	Office Visit Copays Adults/Depts	Deductible Ind/Family	Coinsurance	Coinsurance Max Ind/Family	Rx Options	2-Tier Rates		4-Tier Rates			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/\$1,500	90%	\$500/\$1,500	P R S	\$329.83	\$845.14	\$329.83	\$630.08	\$725.53	\$977.57
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S	\$310.08	\$794.81	\$310.08	\$592.59	\$682.10	\$919.34
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S	\$269.01	\$690.10	\$269.01	\$514.58	\$591.77	\$798.20
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S	\$294.97	\$756.26	\$294.97	\$563.87	\$648.85	\$874.74
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S	\$251.15	\$644.60	\$251.15	\$480.65	\$552.53	\$745.56
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S	\$237.98	\$610.97	\$237.98	\$455.60	\$523.50	\$706.64

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol. Mail Order	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.											
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

11/17/2009

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# EmblemHealth EPO IN-BALANCE

Employer Groups of 2+  
(The EPO is an In-Network-Only Plan) PLH EPO-995/PLH EPO 994C



Rates Effective 1/1/10-3/31/10

## MID-HUDSON

	Office Visit Copays Adults/Depts	Deductible Ind/Family	Coinsurance	Coinsurance Max Ind/Family	Rx Options	2-Tier Rates		4-Tier Rates			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/\$1,500	90%	\$500/\$1,500	P R S	\$301.95	\$774.05	\$301.95	\$577.12	\$664.20	\$895.34
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S	\$283.87	\$728.00	\$283.87	\$542.78	\$624.46	\$842.02
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S	\$246.27	\$632.14	\$246.27	\$471.39	\$541.79	\$731.15
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S	\$270.04	\$692.71	\$270.04	\$516.50	\$594.02	\$801.21
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S	\$229.95	\$590.50	\$229.95	\$440.34	\$505.86	\$682.97
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S	\$217.89	\$559.72	\$217.89	\$417.41	\$479.29	\$647.36

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options								2-Tier Rates		4-Tier Rates			
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic						
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

11/17/2009

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# EmblemHealth EPO IN-BALANCE

Employer Groups of 2+  
(The EPO is an In-Network-Only Plan) PLH EPO-995/PLH EPO 994C



Rates Effective 1/1/10-3/31/10

## ALBANY

	Office Visit Copays Adults/Dep's	Deductible Ind/Family	Coinsurance	Coinsurance Max Ind/Family	Rx Options	2-Tier Rates		4-Tier Rates			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/\$1,500	90%	\$500/\$1,500	P R S	\$267.63	\$686.53	\$267.63	\$511.89	\$588.70	\$794.07
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S	\$251.60	\$645.71	\$251.60	\$481.50	\$553.48	\$746.85
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S	\$218.31	\$560.80	\$218.31	\$418.23	\$480.24	\$648.62
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S	\$239.35	\$614.45	\$239.35	\$458.19	\$526.50	\$710.69
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S	\$203.82	\$523.90	\$203.82	\$390.71	\$448.40	\$605.93
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S	\$193.13	\$496.62	\$193.13	\$370.42	\$424.85	\$574.36

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options								2-Tier Rates		4-Tier Rates			
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic						
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

11/17/2009

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# EmblemHealth EPO IN-BALANCE

Employer Groups of 2+

(The EPO is an In-Network-Only Plan) PLH EPO-995/PLH EPO 994C

Rates Effective 1/1/10-3/31/10

## UTICA/WATERTOWN



	Office Visit Copays Adults/Depts	Deductible Ind/Family	Coinsurance	Coinsurance Max Ind/Family	Rx Options	2-Tier Rates		4-Tier Rates			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/\$1,500	90%	\$500/\$1,500	P R S	\$257.18	\$659.93	\$257.18	\$492.07	\$565.74	\$763.28
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S	\$241.81	\$620.71	\$241.81	\$462.87	\$531.91	\$717.92
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S	\$209.80	\$539.09	\$209.80	\$402.05	\$461.51	\$623.52
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S	\$230.02	\$590.65	\$230.02	\$440.47	\$505.98	\$683.16
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S	\$195.88	\$503.64	\$195.88	\$375.62	\$430.92	\$582.50
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S	\$185.60	\$477.44	\$185.60	\$356.12	\$408.30	\$552.17

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol. Mail Order	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

11/17/2009

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# EmblemHealth EPO IN-BALANCE

Employer Groups of 2+  
(The EPO is an In-Network-Only Plan) PLH EPO-995/PLH EPO 994C



Rates Effective 1/1/10-3/31/10

## SYRACUSE

	Office Visit Copays Adults/Dep's	Deductible Ind/Family	Coinsurance	Coinsurance Max Ind/Family	Rx Options	2-Tier Rates		4-Tier Rates			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/\$1,500	90%	\$500/\$1,500	P R S	\$254.32	\$652.60	\$254.32	\$486.61	\$559.42	\$754.82
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S	\$239.09	\$613.81	\$239.09	\$457.74	\$525.97	\$709.95
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S	\$207.45	\$533.13	\$207.45	\$397.61	\$456.36	\$616.62
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S	\$227.45	\$584.11	\$227.45	\$435.59	\$500.32	\$675.59
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S	\$193.70	\$498.07	\$193.70	\$371.48	\$426.11	\$576.05
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S	\$183.54	\$472.16	\$183.54	\$352.20	\$403.76	\$546.05

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates			4-Tier Rates				
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.	Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order								
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32	
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96	
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24	
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE														

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

11/17/2009

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# EmblemHealth EPO IN-BALANCE

Employer Groups of 2+  
(The EPO is an In-Network-Only Plan) PLH EPO-995/PLH EPO 994C



Rates Effective 1/1/10-3/31/10

## ROCHESTER

	Office Visit Copays Adults/Depts	Deductible Ind/Family	Coinsurance	Coinsurance Max Ind/Family	Rx Options	2-Tier Rates		4-Tier Rates			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/\$1,500	90%	\$500/\$1,500	P R S	\$248.92	\$638.86	\$248.92	\$476.37	\$547.56	\$738.92
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S	\$234.03	\$600.89	\$234.03	\$448.11	\$514.82	\$695.00
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S	\$203.06	\$521.92	\$203.06	\$389.27	\$446.68	\$603.64
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S	\$222.63	\$571.81	\$222.63	\$426.43	\$489.73	\$661.36
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S	\$189.61	\$487.61	\$189.61	\$363.68	\$417.09	\$563.95
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S	\$179.65	\$462.26	\$179.65	\$344.79	\$395.21	\$534.59

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options								2-Tier Rates		4-Tier Rates			
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol. Mail Order	Mand. Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

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# EmblemHealth EPO IN-BALANCE

Employer Groups of 2+  
(The EPO is an In-Network-Only Plan) PLH EPO-995/PLH EPO 994C



Rates Effective 1/1/10-3/31/10

## BUFFALO

	Office Visit Copays Adults/Dep's	Deductible Ind/Family	Coinsurance	Coinsurance Max Ind/Family	Rx Options	2-Tier Rates		4-Tier Rates			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/\$1,500	90%	\$500/\$1,500	P R S	\$251.17	\$644.61	\$251.17	\$480.66	\$552.54	\$745.58
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S	\$236.15	\$606.31	\$236.15	\$452.13	\$519.49	\$701.26
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S	\$204.89	\$526.63	\$204.89	\$392.75	\$450.73	\$609.07
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S	\$224.66	\$576.96	\$224.66	\$430.27	\$494.18	\$667.31
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S	\$191.33	\$492.00	\$191.33	\$366.95	\$420.85	\$569.02
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S	\$181.27	\$466.40	\$181.27	\$347.89	\$398.77	\$539.41

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options								2-Tier Rates		4-Tier Rates			
	Retail Copays			Retail/Brand &	Retail Annual	Home Delivery	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.	Mail Order Ded.*	Maximum	Copays	Mail Order	Generic						
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$115.37	\$294.17	\$115.37	\$219.19	\$253.81	\$340.32
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$88.13	\$224.70	\$88.13	\$167.44	\$193.87	\$259.96
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$67.53	\$172.21	\$67.53	\$128.31	\$148.58	\$199.24
O**	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

\*\*Voluntary Discount Rx Option provides up to 70% Off Retail Prices and up to 75% Off Mail Order Prices

11/17/2009

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# EmblemHealth

## PPO Employer Groups of 2+

PLH SGC 976-2/PLH SGC 976-G

Rates Effective 1/1/10-3/31/10

### DOWNSTATE



	Copays							Rx	2-Tier Rates		4-Tier Rates				
	Adults/Depts	Out of Network Deductible	ER	Out of Network Coinsurance	Inpatient Hospital	Amb Surg	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family	
1	\$40/\$0	\$3,000/\$9,000	\$100	70%/30%	\$500/day x 3	\$500	\$3,000/\$9,000	AA BB CC DD EE	\$495.88	\$1,268.62	\$495.88	\$945.60	\$1,090.88	\$1,467.46	
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$514.87	\$1,317.02	\$514.87	\$981.66	\$1,132.65	\$1,523.46	
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$485.10	\$1,241.11	\$485.10	\$925.11	\$1,067.14	\$1,435.65	
4	\$40/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$519.87	\$1,329.80	\$519.87	\$991.16	\$1,143.64	\$1,538.21	
5	\$40/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$623.69	\$1,594.57	\$623.69	\$1,188.47	\$1,372.09	\$1,844.56	
6	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$563.81	\$1,441.82	\$563.81	\$1,074.65	\$1,240.31	\$1,667.83	
7	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$544.37	\$1,392.25	\$544.37	\$1,037.72	\$1,197.53	\$1,610.50	
8	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$659.00	\$1,684.56	\$659.00	\$1,255.57	\$1,449.77	\$1,948.66	
9	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$571.82	\$1,462.22	\$571.82	\$1,089.86	\$1,257.94	\$1,691.44	
10	\$25/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$729.89	\$1,865.33	\$729.89	\$1,390.20	\$1,605.64	\$2,157.74	
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000							11/17/2009	

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
U	\$0	\$25	\$40	\$0	None	\$0/\$50/\$80	Voluntary	NO	\$175.68	\$447.95	\$175.68	\$333.78	\$386.45	\$518.22
V	\$0	\$25	\$40	\$100	None	\$0/\$50/\$80	Voluntary	NO	\$165.05	\$420.88	\$165.05	\$313.60	\$363.13	\$486.92
W	\$0	\$25	\$40	\$50	\$3,000	\$0/\$50/\$80	Voluntary	NO	\$142.15	\$362.47	\$142.15	\$270.09	\$312.69	\$419.30
X	\$0	\$25	\$40	\$50	\$1,000	\$0/\$50/\$80	Voluntary	NO	\$111.88	\$285.28	\$111.88	\$212.58	\$246.16	\$330.04
Y	\$0	\$25	\$40	\$50	\$750	\$0/\$50/\$80	Voluntary	NO	\$102.33	\$260.92	\$102.33	\$194.39	\$225.09	\$301.85
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

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**EmblemHealth**  
**PPO Employer Groups of 2+**  
 PLH SGC 976-2/PLH SGC 976-G  
 Rates Effective 1/1/10-3/31/10  
**MID-HUDSON**



	Copays							Rx	2-Tier Rates		4-Tier Rates			
	Adults/Depts	Out of Network Deductible	ER	Out of Network Coinsurance	Inpatient Hospital	Amb Surg	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$3,000/\$9,000	\$100	70%/30%	\$500/day x 3	\$500	\$3,000/\$9,000	AA BB CC DD EE	\$474.51	\$1,214.13	\$474.51	\$905.01	\$1,043.90	\$1,404.43
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$487.96	\$1,248.43	\$487.96	\$930.58	\$1,073.50	\$1,444.10
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$464.20	\$1,187.84	\$464.20	\$885.43	\$1,021.22	\$1,374.04
4	\$40/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$497.42	\$1,272.58	\$497.42	\$948.54	\$1,094.30	\$1,472.01
5	\$40/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$588.13	\$1,503.90	\$588.13	\$1,120.93	\$1,293.90	\$1,739.65
6	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$526.77	\$1,347.35	\$526.77	\$1,004.30	\$1,158.84	\$1,558.55
7	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$508.61	\$1,301.12	\$508.61	\$969.83	\$1,118.94	\$1,505.07
8	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$621.37	\$1,588.65	\$621.37	\$1,184.10	\$1,367.04	\$1,837.71
9	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$534.22	\$1,366.39	\$534.22	\$1,018.46	\$1,175.29	\$1,580.59
10	\$25/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$681.68	\$1,742.40	\$681.68	\$1,298.61	\$1,499.60	\$2,015.50
In-Network Annual Maximum: Unlimited										Out-of-Network Annual Maximum: \$1,000,000				11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
U	\$0	\$25	\$40	\$0	None	\$0/\$50/\$80	Voluntary	NO	\$175.68	\$447.95	\$175.68	\$333.78	\$386.45	\$518.22
V	\$0	\$25	\$40	\$100	None	\$0/\$50/\$80	Voluntary	NO	\$165.05	\$420.88	\$165.05	\$313.60	\$363.13	\$486.92
W	\$0	\$25	\$40	\$50	\$3,000	\$0/\$50/\$80	Voluntary	NO	\$142.15	\$362.47	\$142.15	\$270.09	\$312.69	\$419.30
X	\$0	\$25	\$40	\$50	\$1,000	\$0/\$50/\$80	Voluntary	NO	\$111.88	\$285.28	\$111.88	\$212.58	\$246.16	\$330.04
Y	\$0	\$25	\$40	\$50	\$750	\$0/\$50/\$80	Voluntary	NO	\$102.33	\$260.92	\$102.33	\$194.39	\$225.09	\$301.85
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

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**EmblemHealth**  
**PPO Employer Groups of 2+**  
 PLH SGC 976-2/PLH SGC 976-G  
 Rates Effective 1/1/10-3/31/10  
**ALBANY**



	Copays							Rx	2-Tier Rates		4-Tier Rates				
	Adults/Depts	Out of Network Deductible	ER	Out of Network Coinsurance	Inpatient Hospital	Amb Surg	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family	
1	\$40/\$0	\$3,000/\$9,000	\$100	70%/30%	\$500/day x 3	\$500	\$3,000/\$9,000	AA BB CC DD EE	\$421.94	\$1,080.06	\$421.94	\$805.13	\$928.22	\$1,249.35	
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$433.88	\$1,110.55	\$433.88	\$827.83	\$954.51	\$1,284.58	
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$412.77	\$1,056.70	\$412.77	\$787.73	\$908.09	\$1,222.32	
4	\$40/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$442.30	\$1,131.93	\$442.30	\$843.78	\$973.01	\$1,309.37	
5	\$40/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$522.89	\$1,337.48	\$522.89	\$996.93	\$1,150.31	\$1,547.15	
6	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$468.35	\$1,198.40	\$468.35	\$893.30	\$1,030.33	\$1,386.23	
7	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$452.25	\$1,157.36	\$452.25	\$862.72	\$994.90	\$1,338.75	
8	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$552.46	\$1,412.78	\$552.46	\$1,053.04	\$1,215.30	\$1,634.26	
9	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$474.99	\$1,215.31	\$474.99	\$905.95	\$1,044.93	\$1,405.81	
10	\$25/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$605.96	\$1,549.31	\$605.96	\$1,154.77	\$1,333.06	\$1,792.20	
In-Network Annual Maximum: Unlimited								Out-of-Network Annual Maximum: \$1,000,000							

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
U	\$0	\$25	\$40	\$0	None	\$0/\$50/\$80	Voluntary	NO	\$175.68	\$447.95	\$175.68	\$333.78	\$386.45	\$518.22
V	\$0	\$25	\$40	\$100	None	\$0/\$50/\$80	Voluntary	NO	\$165.05	\$420.88	\$165.05	\$313.60	\$363.13	\$486.92
W	\$0	\$25	\$40	\$50	\$3,000	\$0/\$50/\$80	Voluntary	NO	\$142.15	\$362.47	\$142.15	\$270.09	\$312.69	\$419.30
X	\$0	\$25	\$40	\$50	\$1,000	\$0/\$50/\$80	Voluntary	NO	\$111.88	\$285.28	\$111.88	\$212.58	\$246.16	\$330.04
Y	\$0	\$25	\$40	\$50	\$750	\$0/\$50/\$80	Voluntary	NO	\$102.33	\$260.92	\$102.33	\$194.39	\$225.09	\$301.85
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

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**EmblemHealth**  
**PPO Employer Groups of 2+**  
 PLH SGC 976-2/PLH SGC 976-G  
 Rates Effective **1/1/10-3/31/10**  
**UTICA/WATERTOWN**



	Copays							Rx	2-Tier Rates		4-Tier Rates			
	Adults/Depts	Out of Network Deductible	ER	Out of Network Coinsurance	Inpatient Hospital	Amb Surg	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$3,000/\$9,000	\$100	70%/30%	\$500/day x 3	\$500	\$3,000/\$9,000	AA BB CC DD EE	\$404.52	\$1,035.67	\$404.52	\$772.06	\$889.92	\$1,197.99
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$415.98	\$1,064.89	\$415.98	\$793.81	\$915.13	\$1,231.75
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$395.75	\$1,013.30	\$395.75	\$755.37	\$870.64	\$1,172.09
4	\$40/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$424.05	\$1,085.38	\$424.05	\$809.09	\$932.84	\$1,255.51
5	\$40/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$501.29	\$1,282.37	\$501.29	\$955.87	\$1,102.77	\$1,483.40
6	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$449.02	\$1,149.09	\$449.02	\$856.56	\$987.79	\$1,329.18
7	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$433.58	\$1,109.76	\$433.58	\$827.23	\$953.83	\$1,283.68
8	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$529.62	\$1,354.54	\$529.62	\$1,009.65	\$1,165.07	\$1,566.87
9	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$455.38	\$1,165.29	\$455.38	\$868.68	\$1,001.78	\$1,347.94
10	\$25/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$580.89	\$1,485.40	\$580.89	\$1,107.15	\$1,277.92	\$1,718.27
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000							11/17/2009

Please select an Rx Option that is listed above as available with your Rx plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
U	\$0	\$25	\$40	\$0	None	\$0/\$50/\$80	Voluntary	NO	\$175.68	\$447.95	\$175.68	\$333.78	\$386.45	\$518.22
V	\$0	\$25	\$40	\$100	None	\$0/\$50/\$80	Voluntary	NO	\$165.05	\$420.88	\$165.05	\$313.60	\$363.13	\$486.92
W	\$0	\$25	\$40	\$50	\$3,000	\$0/\$50/\$80	Voluntary	NO	\$142.15	\$362.47	\$142.15	\$270.09	\$312.69	\$419.30
X	\$0	\$25	\$40	\$50	\$1,000	\$0/\$50/\$80	Voluntary	NO	\$111.88	\$285.28	\$111.88	\$212.58	\$246.16	\$330.04
Y	\$0	\$25	\$40	\$50	\$750	\$0/\$50/\$80	Voluntary	NO	\$102.33	\$260.92	\$102.33	\$194.39	\$225.09	\$301.85
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

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# EmblemHealth

## PPO Employer Groups of 2+

PLH SGC 976-2/PLH SGC 976-G

Rates Effective 1/1/10-3/31/10

### SYRACUSE



	Copays							Rx	2-Tier Rates		4-Tier Rates				
	Adults/Depts	Out of Network Deductible	ER	Out of Network Coinsurance	Inpatient Hospital	Amb Surg	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family	
1	\$40/\$0	\$3,000/\$9,000	\$100	70%/30%	\$500/day x 3	\$500	\$3,000/\$9,000	AA BB CC DD EE	\$390.80	\$1,000.65	\$390.80	\$745.97	\$859.72	\$1,157.48	
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$401.86	\$1,028.87	\$401.86	\$766.98	\$884.05	\$1,190.10	
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$382.32	\$979.05	\$382.32	\$729.86	\$841.09	\$1,132.48	
4	\$40/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$409.65	\$1,048.68	\$409.65	\$781.74	\$901.17	\$1,213.04	
5	\$40/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$484.25	\$1,238.92	\$484.25	\$923.48	\$1,065.27	\$1,433.13	
6	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$433.77	\$1,110.20	\$433.77	\$827.58	\$954.24	\$1,284.19	
7	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$418.85	\$1,072.19	\$418.85	\$799.26	\$921.44	\$1,240.25	
8	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$511.61	\$1,308.62	\$511.61	\$975.43	\$1,125.44	\$1,513.76	
9	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$439.90	\$1,125.83	\$439.90	\$839.28	\$967.75	\$1,302.31	
10	\$25/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$561.13	\$1,434.99	\$561.13	\$1,069.58	\$1,234.44	\$1,659.93	
<b>In-Network Annual Maximum: Unlimited</b>							<b>Out-of-Network Annual Maximum: \$1,000,000</b>							11/17/2009	

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
U	\$0	\$25	\$40	\$0	None	\$0/\$50/\$80	Voluntary	NO	\$175.68	\$447.95	\$175.68	\$333.78	\$386.45	\$518.22
V	\$0	\$25	\$40	\$100	None	\$0/\$50/\$80	Voluntary	NO	\$165.05	\$420.88	\$165.05	\$313.60	\$363.13	\$486.92
W	\$0	\$25	\$40	\$50	\$3,000	\$0/\$50/\$80	Voluntary	NO	\$142.15	\$362.47	\$142.15	\$270.09	\$312.69	\$419.30
X	\$0	\$25	\$40	\$50	\$1,000	\$0/\$50/\$80	Voluntary	NO	\$111.88	\$285.28	\$111.88	\$212.58	\$246.16	\$330.04
Y	\$0	\$25	\$40	\$50	\$750	\$0/\$50/\$80	Voluntary	NO	\$102.33	\$260.92	\$102.33	\$194.39	\$225.09	\$301.85
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

No exceptions, including typographical errors or omissions, will be applied or accepted.



**EmblemHealth**  
**PPO Employer Groups of 2+**  
 PLH SGC 976-2/PLH SGC 976-G  
 Rates Effective 1/1/10-3/31/10  
**ROCHESTER**



	Copays							Rx	2-Tier Rates		4-Tier Rates			
	Adults/Depts	Out of Network Deductible	ER	Out of Network Coinsurance	Inpatient Hospital	Amb Surg	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$3,000/\$9,000	\$100	70%/30%	\$500/day x 3	\$500	\$3,000/\$9,000	AA BB CC DD EE	\$392.41	\$1,004.77	\$392.41	\$749.02	\$863.27	\$1,162.22
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$403.51	\$1,033.08	\$403.51	\$770.11	\$887.70	\$1,194.99
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$383.89	\$983.09	\$383.89	\$732.86	\$844.56	\$1,137.13
4	\$40/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$408.61	\$1,046.11	\$408.61	\$779.83	\$898.95	\$1,210.06
5	\$40/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$483.04	\$1,235.86	\$483.04	\$921.21	\$1,062.64	\$1,429.60
6	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$435.55	\$1,114.75	\$435.55	\$830.98	\$958.17	\$1,289.47
7	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$420.56	\$1,076.59	\$420.56	\$802.52	\$925.22	\$1,245.30
8	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$510.28	\$1,305.38	\$510.28	\$973.03	\$1,122.62	\$1,510.00
9	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$438.83	\$1,123.11	\$438.83	\$837.19	\$965.36	\$1,299.12
10	\$25/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$559.72	\$1,431.46	\$559.72	\$1,066.95	\$1,231.39	\$1,655.86
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000							

11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol. Mail Order	Mand. Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
U	\$0	\$25	\$40	\$0	None	\$0/\$50/\$80	Voluntary	NO	\$175.68	\$447.95	\$175.68	\$333.78	\$386.45	\$518.22
V	\$0	\$25	\$40	\$100	None	\$0/\$50/\$80	Voluntary	NO	\$165.05	\$420.88	\$165.05	\$313.60	\$363.13	\$486.92
W	\$0	\$25	\$40	\$50	\$3,000	\$0/\$50/\$80	Voluntary	NO	\$142.15	\$362.47	\$142.15	\$270.09	\$312.69	\$419.30
X	\$0	\$25	\$40	\$50	\$1,000	\$0/\$50/\$80	Voluntary	NO	\$111.88	\$285.28	\$111.88	\$212.58	\$246.16	\$330.04
Y	\$0	\$25	\$40	\$50	\$750	\$0/\$50/\$80	Voluntary	NO	\$102.33	\$260.92	\$102.33	\$194.39	\$225.09	\$301.85
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

No exceptions, including typographical errors or omissions, will be applied or accepted.



**EmblemHealth**  
**PPO Employer Groups of 2+**  
 PLH SGC 976-2/PLH SGC 976-G  
 Rates Effective 1/1/10-3/31/10  
**BUFFALO**



	Copays							Rx	2-Tier Rates		4-Tier Rates			
	Adults/Depts	Out of Network Deductible	ER	Out of Network Coinsurance	Inpatient Hospital	Amb Surg	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$3,000/\$9,000	\$100	70%/30%	\$500/day x 3	\$500	\$3,000/\$9,000	AA BB CC DD EE	\$397.54	\$1,017.86	\$397.54	\$758.77	\$874.57	\$1,177.36
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$408.79	\$1,046.56	\$408.79	\$780.15	\$899.33	\$1,210.56
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$388.92	\$995.88	\$388.92	\$742.40	\$855.60	\$1,151.95
4	\$40/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$414.03	\$1,059.85	\$414.03	\$790.06	\$910.80	\$1,225.95
5	\$40/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$489.40	\$1,252.13	\$489.40	\$933.31	\$1,076.68	\$1,448.39
6	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$441.25	\$1,129.33	\$441.25	\$841.85	\$970.73	\$1,306.32
7	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$426.07	\$1,090.63	\$426.07	\$812.99	\$937.34	\$1,261.55
8	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$0	\$0	\$3,000/\$9,000	U V W X Y	\$517.00	\$1,322.58	\$517.00	\$985.79	\$1,137.47	\$1,529.85
9	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$444.60	\$1,137.84	\$444.60	\$848.20	\$978.07	\$1,316.20
10	\$25/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$0	\$3,000/\$9,000	U V W X Y	\$567.18	\$1,450.35	\$567.18	\$1,080.99	\$1,247.65	\$1,677.67
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000							11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol. Mail Order	Mand. Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
U	\$0	\$25	\$40	\$0	None	\$0/\$50/\$80	Voluntary	NO	\$175.68	\$447.95	\$175.68	\$333.78	\$386.45	\$518.22
V	\$0	\$25	\$40	\$100	None	\$0/\$50/\$80	Voluntary	NO	\$165.05	\$420.88	\$165.05	\$313.60	\$363.13	\$486.92
W	\$0	\$25	\$40	\$50	\$3,000	\$0/\$50/\$80	Voluntary	NO	\$142.15	\$362.47	\$142.15	\$270.09	\$312.69	\$419.30
X	\$0	\$25	\$40	\$50	\$1,000	\$0/\$50/\$80	Voluntary	NO	\$111.88	\$285.28	\$111.88	\$212.58	\$246.16	\$330.04
Y	\$0	\$25	\$40	\$50	\$750	\$0/\$50/\$80	Voluntary	NO	\$102.33	\$260.92	\$102.33	\$194.39	\$225.09	\$301.85
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

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No exceptions, including typographical errors or omissions, will be applied or accepted.



**EmblemHealth**  
**PPO IN-BALANCE**  
 Employer Groups of 2+  
 PLH SGC 991/PLH SGC 990-C  
 Rates Effective 1/1/10-3/31/10  
**DOWNSTATE**



Adults/Depts	Copays						Rx	2-Tier Rates		4-Tier Rates				
	In Network Deductible	Out of Network Deductible	In Network Coinsurance	Out of Network Coinsurance	In Network Coinsurance Max	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family	
1	\$40/\$0	\$2,000/\$6,000	\$4,000/\$12,000	80%/20%	60%/40%	\$10,000/\$30,000	\$20,000/\$60,000	AA BB CC DD EE	\$374.60	\$959.35	\$374.60	\$715.17	\$824.09	\$1,109.67
2	\$40/\$0	\$1,000/\$3,000	\$2,000/\$6,000	80%/20%	60%/40%	\$3,000/\$9,000	\$6,000/\$18,000	AA BB CC DD EE	\$446.93	\$1,143.78	\$446.93	\$852.58	\$983.18	\$1,323.06
3	\$30/\$0	\$1,000/\$3,000	\$2,000/\$6,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$523.43	\$1,338.82	\$523.43	\$997.94	\$1,151.49	\$1,548.72
4	\$25/\$0	\$500/\$1,500	\$1,000/\$3,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$575.53	\$1,471.69	\$575.53	\$1,096.95	\$1,266.11	\$1,702.40
In-Network Annual Maximum: Unlimited						Out-of-Network Annual Maximum: \$1,000,000								11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options						2-Tier Rates		4-Tier Rates					
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol. Mail Order	Mand. Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

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State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

No exceptions, including typographical errors or omissions, will be applied or accepted.



# EmblemHealth PPO IN-BALANCE

Employer Groups of 2+

PLH SGC 991/PLH SGC 990-C

Rates Effective 1/1/10-3/31/10

## MID-HUDSON



Adults/Deps	Copays						Rx Options	2-Tier Rates		4-Tier Rates				
	In Network Deductible	Out of Network Deductible	In Network Coinsurance	Out of Network Coinsurance	In Network Coinsurance Max	Out of Network Coinsurance Max		Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family	
1	\$40/\$0	\$2,000/\$6,000	\$4,000/\$12,000	80%/20%	60%/40%	\$10,000/\$30,000	\$20,000/\$60,000	AA BB CC DD EE	\$343.76	\$880.71	\$343.76	\$656.58	\$756.25	\$1,018.68
2	\$40/\$0	\$1,000/\$3,000	\$2,000/\$6,000	80%/20%	60%/40%	\$3,000/\$9,000	\$6,000/\$18,000	AA BB CC DD EE	\$410.12	\$1,049.92	\$410.12	\$782.66	\$902.20	\$1,214.48
3	\$30/\$0	\$1,000/\$3,000	\$2,000/\$6,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$480.30	\$1,228.86	\$480.30	\$916.01	\$1,056.64	\$1,421.51
4	\$25/\$0	\$500/\$1,500	\$1,000/\$3,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$528.10	\$1,350.78	\$528.10	\$1,006.85	\$1,161.78	\$1,562.53
In-Network Annual Maximum: Unlimited						Out-of-Network Annual Maximum: \$1,000,000								11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol. Mail Order	Mand. Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

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# EmblemHealth PPO IN-BALANCE

Employer Groups of 2+

PLH SGC 991/PLH SGC 990-C

Rates Effective 1/1/10-3/31/10

## ALBANY



Adults/Deps	Copays						Rx	2-Tier Rates		4-Tier Rates				
	In Network Deductible	Out of Network Deductible	In Network Coinsurance	Out of Network Coinsurance	In Network Coinsurance Max	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family	
1	\$40/\$0	\$2,000/\$6,000	\$4,000/\$12,000	80%/20%	60%/40%	\$10,000/\$30,000	\$20,000/\$60,000	AA BB CC DD EE	\$303.83	\$778.79	\$303.83	\$580.65	\$668.29	\$900.80
2	\$40/\$0	\$1,000/\$3,000	\$2,000/\$6,000	80%/20%	60%/40%	\$3,000/\$9,000	\$6,000/\$18,000	AA BB CC DD EE	\$362.44	\$928.31	\$362.44	\$692.05	\$797.29	\$1,073.76
3	\$30/\$0	\$1,000/\$3,000	\$2,000/\$6,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$424.43	\$1,086.42	\$424.43	\$809.88	\$933.72	\$1,256.66
4	\$25/\$0	\$500/\$1,500	\$1,000/\$3,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$466.68	\$1,194.10	\$466.68	\$890.12	\$1,026.62	\$1,381.28
In-Network Annual Maximum: Unlimited						Out-of-Network Annual Maximum: \$1,000,000						11/17/2009		

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol. Mail Order	Mand. Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

No exceptions, including typographical errors or omissions, will be applied or accepted.



# EmblemHealth PPO IN-BALANCE

Employer Groups of 2+

PLH SGC 991/PLH SGC 990-C

Rates Effective 1/1/10-3/31/10

## UTICA/WATERTOWN



Adults/Deps	Copays						Rx	2-Tier Rates		4-Tier Rates				
	In Network Deductible	Out of Network Deductible	In Network Coinsurance	Out of Network Coinsurance	In Network Coinsurance Max	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family	
1	\$40/\$0	\$2,000/\$6,000	\$4,000/\$12,000	80%/20%	60%/40%	\$10,000/\$30,000	\$20,000/\$60,000	AA BB CC DD EE	\$292.15	\$748.99	\$292.15	\$558.43	\$642.58	\$866.32
2	\$40/\$0	\$1,000/\$3,000	\$2,000/\$6,000	80%/20%	60%/40%	\$3,000/\$9,000	\$6,000/\$18,000	AA BB CC DD EE	\$348.49	\$892.74	\$348.49	\$665.54	\$766.60	\$1,032.60
3	\$30/\$0	\$1,000/\$3,000	\$2,000/\$6,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$408.08	\$1,044.74	\$408.08	\$778.81	\$897.76	\$1,208.45
4	\$25/\$0	\$500/\$1,500	\$1,000/\$3,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$448.71	\$1,148.28	\$448.71	\$855.97	\$987.08	\$1,328.27
In-Network Annual Maximum: Unlimited						Out-of-Network Annual Maximum: \$1,000,000								11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

No exceptions, including typographical errors or omissions, will be applied or accepted.



# EmblemHealth PPO IN-BALANCE

Employer Groups of 2+

PLH SGC 991/PLH SGC 990-C

Rates Effective 1/1/10-3/31/10

## SYRACUSE



Adults/Deps	Copays						Rx	2-Tier Rates		4-Tier Rates				
	In Network Deductible	Out of Network Deductible	In Network Coinsurance	Out of Network Coinsurance	In Network Coinsurance Max	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family	
1	\$40/\$0	\$2,000/\$6,000	\$4,000/\$12,000	80%/20%	60%/40%	\$10,000/\$30,000	\$20,000/\$60,000	AA BB CC DD EE	\$284.80	\$730.27	\$284.80	\$544.48	\$626.43	\$844.65
2	\$40/\$0	\$1,000/\$3,000	\$2,000/\$6,000	80%/20%	60%/40%	\$3,000/\$9,000	\$6,000/\$18,000	AA BB CC DD EE	\$339.73	\$870.38	\$339.73	\$648.88	\$747.32	\$1,006.75
3	\$30/\$0	\$1,000/\$3,000	\$2,000/\$6,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$397.82	\$1,018.56	\$397.82	\$759.31	\$875.17	\$1,178.16
4	\$25/\$0	\$500/\$1,500	\$1,000/\$3,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$437.42	\$1,119.48	\$437.42	\$834.52	\$962.25	\$1,294.95
<b>In-Network Annual Maximum: Unlimited</b>						<b>Out-of-Network Annual Maximum: \$1,000,000</b>						11/17/2009		

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options						2-Tier Rates		4-Tier Rates					
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

Rate illustrations are provided for convenience only and are in no way considered to be proposals, advertisements, or implied contracts for insurance coverage.

State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

No exceptions, including typographical errors or omissions, will be applied or accepted.



# EmblemHealth PPO IN-BALANCE

Employer Groups of 2+

PLH SGC 991/PLH SGC 990-C

Rates Effective 1/1/10-3/31/10

## ROCHESTER



	Copays						Rx	2-Tier Rates		4-Tier Rates				
	Adults/Depts	In Network Deductible	Out of Network Deductible	In Network Coinsurance	Out of Network Coinsurance	In Network Coinsurance Max	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$2,000/\$6,000	\$4,000/\$12,000	80%/20%	60%/40%	\$10,000/\$30,000	\$20,000/\$60,000	AA BB CC DD EE	\$282.71	\$724.98	\$282.71	\$540.57	\$621.87	\$838.55
2	\$40/\$0	\$1,000/\$3,000	\$2,000/\$6,000	80%/20%	60%/40%	\$3,000/\$9,000	\$6,000/\$18,000	AA BB CC DD EE	\$337.22	\$864.08	\$337.22	\$644.21	\$741.86	\$999.47
3	\$30/\$0	\$1,000/\$3,000	\$2,000/\$6,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$394.92	\$1,011.17	\$394.92	\$753.81	\$868.79	\$1,169.65
4	\$25/\$0	\$500/\$1,500	\$1,000/\$3,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$434.21	\$1,111.36	\$434.21	\$828.47	\$955.25	\$1,285.56
In-Network Annual Maximum: Unlimited						Out-of-Network Annual Maximum: \$1,000,000								11/17/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options							2-Tier Rates		4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol. Mail Order	Mand. Generic	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

Rates are subject to EmblemHealth and NYS Insurance Department Approval.

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State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.

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**EmblemHealth**  
**PPO IN-BALANCE**  
 Employer Groups of 2+  
 PLH SGC 991/PLH SGC 990-C  
 Rates Effective 1/1/10-3/31/10  
**BUFFALO**



Adults/Deps	Copays						Rx	2-Tier Rates		4-Tier Rates				
	In Network Deductible	Out of Network Deductible	In Network Coinsurance	Out of Network Coinsurance	In Network Coinsurance Max	Out of Network Coinsurance Max	Options	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family	
1	\$40/\$0	\$2,000/\$6,000	\$4,000/\$12,000	80%/20%	60%/40%	\$10,000/\$30,000	\$20,000/\$60,000	AA BB CC DD EE	\$285.30	\$731.55	\$285.30	\$545.47	\$627.56	\$846.17
2	\$40/\$0	\$1,000/\$3,000	\$2,000/\$6,000	80%/20%	60%/40%	\$3,000/\$9,000	\$6,000/\$18,000	AA BB CC DD EE	\$340.31	\$871.93	\$340.31	\$650.03	\$748.64	\$1,008.56
3	\$30/\$0	\$1,000/\$3,000	\$2,000/\$6,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$398.55	\$1,020.37	\$398.55	\$760.68	\$876.72	\$1,180.30
4	\$25/\$0	\$500/\$1,500	\$1,000/\$3,000	90%/10%	70%/30%	\$500/\$1,500	\$1,500/\$4,500	AA BB CC DD EE	\$438.19	\$1,121.48	\$438.19	\$835.99	\$963.98	\$1,297.24
In-Network Annual Maximum: Unlimited						Out-of-Network Annual Maximum: \$1,000,000						11/17/2009		

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options						2-Tier Rates		4-Tier Rates					
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copays	Mand./Vol.	Mand.	Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$129.24	\$329.56	\$129.24	\$245.55	\$284.32	\$381.27
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$121.23	\$309.14	\$121.23	\$230.34	\$266.71	\$357.63
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$98.26	\$250.59	\$98.26	\$186.71	\$216.18	\$289.88
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$75.06	\$191.41	\$75.06	\$142.62	\$165.14	\$221.43
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$69.15	\$176.36	\$69.15	\$131.40	\$152.15	\$204.03

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/17/2009

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**EmblemHealth**

**CONSUMER DIRECT EPO/PPO**

**HSA Compatible Plans Available for Employer Groups of 1+**

(The EPO is an In-Network-Only Plan) PLH SGC 997/PLH SGC 1000

Rates Effective 1/1/10-3/31/10

**DOWNSTATE**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$319.99	\$815.97	\$319.99	\$607.98	\$703.97	\$943.96
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$265.90	\$678.05	\$265.90	\$505.22	\$584.99	\$784.42
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$242.09	\$617.33	\$242.09	\$460.00	\$532.60	\$714.18
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$177.55	\$452.73	\$177.55	\$337.31	\$390.57	\$523.73
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$122.67	\$312.82	\$122.67	\$233.08	\$269.88	\$361.88

**PPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
	Par/Non-Par	Par/Non-Par	Par/Non-Par Max		Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$326.70	\$882.12	\$326.70	\$637.08	\$741.63	\$1,040.56
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$335.31	\$855.07	\$335.31	\$637.10	\$737.71	\$989.18
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$235.70	\$636.38	\$235.70	\$459.61	\$535.03	\$750.69
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$245.23	\$625.34	\$245.23	\$465.93	\$539.51	\$723.43

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$204.14	\$520.56
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$141.06	\$359.73

**PPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
	Par/Non-Par	Par/Non-Par	Par/Non-Par Max		Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$281.98	\$719.07

**Preventive Care is covered 100%.**  
*In-Network Routine Physicals, Screenings Immunizations, and Well Baby Care are not subject to deductible, coinsurance, or a copay! All your payments count! Emblem's "Shared Deductible" feature means money you spend counts toward both your In-Network and Out-of-Network deductibles -helping you satisfy your deductibles faster!*

\* All Family levels are 2x the Individual level.

11/23/2009

\*\*This plan is not compatible with an HSA account and functions only as a high deductible plan.

**Rates are subject to EmblemHealth and NYS Insurance Department Approval.**

**Rate illustrations provided for convenience only and are in no way considered proposals, advertisements, or implied contracts for insurance coverage.**

**State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.**

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**EmblemHealth**

**CONSUMER DIRECT EPO/PPO**

**HSA Compatible Plans Available for Employer Groups of 1+**

(The EPO is an In-Network-Only Plan) PLH SGC 997/PLH SGC 1000

Rates Effective 1/1/10-3/31/10

**MID-HUDSON**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$289.94	\$739.35	\$289.94	\$550.90	\$637.88	\$855.33
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$240.98	\$614.51	\$240.98	\$457.87	\$530.16	\$710.90
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$219.40	\$559.48	\$219.40	\$416.88	\$482.69	\$647.25
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$160.91	\$410.30	\$160.91	\$305.69	\$353.97	\$474.65
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$111.16	\$283.45	\$111.16	\$211.19	\$244.54	\$327.90

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$301.90	\$815.12	\$301.90	\$588.69	\$685.30	\$961.53
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$309.84	\$790.12	\$309.84	\$588.71	\$681.68	\$914.06
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$217.80	\$588.05	\$217.80	\$424.70	\$494.39	\$693.67
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$226.61	\$577.85	\$226.61	\$430.54	\$498.53	\$668.48

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$185.01	\$471.77
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$127.81	\$325.96

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$260.56	\$664.45

\* All Family levels are 2x the Individual level.

11/23/2009

\*\*This plan is not compatible with an HSA account and functions only as a high deductible plan.

**Rates are subject to EmblemHealth and NYS Insurance Department Approval.**

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**State-filed monthly rates will apply at the point of enrollment. Monthly rates and subscriber enrollment are ultimately subject to final carrier approval.**

**No exceptions, including typographical errors or omissions, will be applied or accepted.**

**Preventive Care is covered 100%.**  
*In-Network Routine Physicals, Screenings Immunizations, and Well Baby Care are not subject to deductible, coinsurance, or a copay! All your payments count! Emblem's "Shared Deductible" feature means money you spend counts toward both your In-Network and Out-of-Network deductibles -helping you satisfy your deductibles faster!*



**EmblemHealth**

**CONSUMER DIRECT EPO/PPO**

**HSA Compatible Plans Available for Employer Groups of 1+**

*(The EPO is an In-Network-Only Plan) PLH SGC 997/PLH SGC 1000*

**Rates Effective 1/1/10-3/31/10**

**ALBANY**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
<b>E 2</b>	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$271.89	\$693.30	\$271.89	\$516.58	\$598.15	\$802.06
<b>E 3</b>	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$225.96	\$576.20	\$225.96	\$429.33	\$497.12	\$666.60
<b>E 4</b>	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$205.73	\$524.61	\$205.73	\$390.88	\$452.62	\$606.90
<b>E 5</b>	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$150.88	\$384.73	\$150.88	\$286.67	\$331.92	\$445.06
<b>E 6**</b>	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$104.23	\$265.79	\$104.23	\$198.04	\$229.31	\$307.48

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
<b>P 1</b>	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$283.09	\$764.33	\$283.09	\$552.01	\$642.60	\$901.61
<b>P 2</b>	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$290.52	\$740.88	\$290.52	\$552.03	\$639.19	\$857.07
<b>P 3</b>	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$204.23	\$551.40	\$204.23	\$398.23	\$463.58	\$650.43
<b>P 4</b>	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$212.48	\$541.84	\$212.48	\$403.72	\$467.45	\$626.81

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
<b>SPE 1</b>	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$173.46	\$442.37
<b>SPE 2**</b>	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$119.85	\$305.66

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
<b>SPP</b>	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$244.34	\$623.04

\* All Family levels are 2x the Individual level.

11/23/2009

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**EmblemHealth**

**CONSUMER DIRECT EPO/PPO**

**HSA Compatible Plans Available for Employer Groups of 1+**

(The EPO is an In-Network-Only Plan) PLH SGC 997/PLH SGC 1000

Rates Effective 1/1/10-3/31/10

**UTICA/WATERTOWN**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$261.10	\$665.81	\$261.10	\$496.10	\$574.44	\$770.25
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$216.92	\$553.14	\$216.92	\$412.15	\$477.22	\$639.91
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$197.49	\$503.61	\$197.49	\$375.24	\$434.50	\$582.61
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$144.85	\$369.33	\$144.85	\$275.19	\$318.63	\$427.24
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$100.11	\$255.25	\$100.11	\$190.19	\$220.22	\$295.30

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$271.75	\$733.73	\$271.75	\$529.90	\$616.88	\$865.52
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$278.90	\$711.22	\$278.90	\$529.92	\$613.61	\$822.77
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$196.05	\$529.33	\$196.05	\$382.28	\$445.02	\$624.39
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$203.97	\$520.14	\$203.97	\$387.57	\$448.74	\$601.71

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$166.52	\$424.66
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$115.10	\$293.55

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$234.56	\$598.10

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11/23/2009

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Rates Effective 1/1/10-3/31/10

**SYRACUSE**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$261.74	\$667.46	\$261.74	\$497.33	\$575.84	\$772.15
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$217.62	\$554.92	\$217.62	\$413.48	\$478.76	\$641.99
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$198.13	\$505.24	\$198.13	\$376.45	\$435.91	\$584.49
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$145.31	\$370.52	\$145.31	\$276.08	\$319.67	\$428.63
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$100.34	\$255.87	\$100.34	\$190.65	\$220.75	\$296.00

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$272.63	\$736.09	\$272.63	\$531.62	\$618.87	\$868.33
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$279.80	\$713.53	\$279.80	\$531.64	\$615.58	\$825.44
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$196.68	\$531.04	\$196.68	\$383.53	\$446.46	\$626.42
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$204.63	\$521.83	\$204.63	\$388.80	\$450.19	\$603.66

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$167.06	\$426.04
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$115.38	\$294.24

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$235.32	\$600.03

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Rates Effective 1/1/10-3/31/10

**ROCHESTER**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$253.18	\$645.61	\$253.18	\$481.05	\$557.00	\$746.89
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$210.42	\$536.56	\$210.42	\$399.78	\$462.91	\$620.73
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$191.58	\$488.51	\$191.58	\$363.99	\$421.46	\$565.14
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$140.48	\$358.23	\$140.48	\$266.92	\$309.06	\$414.43
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$97.07	\$247.51	\$97.07	\$184.42	\$213.55	\$286.34

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$263.60	\$711.71	\$263.60	\$514.01	\$598.36	\$839.55
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$270.54	\$689.88	\$270.54	\$514.03	\$595.19	\$798.10
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$190.17	\$513.45	\$190.17	\$370.83	\$431.67	\$605.68
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$197.86	\$504.55	\$197.86	\$375.94	\$435.29	\$583.67

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$161.55	\$411.93
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$111.61	\$284.63

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$227.49	\$580.16

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Rates Effective 1/1/10-3/31/10

**BUFFALO**



**EPO (Employer Groups of 2+)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
E 2	\$1,500	100%	\$1,500	After Deductible Covered in Full	\$256.98	\$655.33	\$256.98	\$488.28	\$565.37	\$758.11
E 3	\$2,500	100%	\$2,500	After Deductible Covered in Full	\$213.46	\$544.32	\$213.46	\$405.57	\$469.61	\$629.71
E 4	\$3,000	100%	\$3,000	After Deductible Covered in Full	\$194.35	\$495.57	\$194.35	\$369.26	\$427.56	\$573.31
E 5	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$142.51	\$363.44	\$142.51	\$270.78	\$313.55	\$420.43
E 6**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$98.53	\$251.24	\$98.53	\$187.19	\$216.76	\$290.65

**PPO (Employer Groups of 2+)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates		4-Tier Rates			
					Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P 1	\$2,500/\$2,500	100%/70%	\$2,500/\$5,500	After Deductible Covered in Full	\$267.42	\$722.03	\$267.42	\$521.45	\$607.05	\$851.72
P 2	\$2,500/\$5,000	100%/80%	\$2,500/\$7,000	After Deductible Covered in Full	\$274.47	\$699.87	\$274.47	\$521.48	\$603.80	\$809.66
P 3	\$5,000/\$5,000	100%/70%	\$5,000/\$8,000	After Deductible Covered in Full	\$192.93	\$520.89	\$192.93	\$376.20	\$437.93	\$614.47
P 4	\$5,000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$200.72	\$511.84	\$200.72	\$381.38	\$441.59	\$592.12

**EPO (Sole Proprietor Groups)**

	Deductible*	Coinsurance	Out of Pocket Maximum*	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPE 1	\$5,800	100%	\$5,800	After Deductible Covered in Full	\$163.88	\$417.90
SPE 2**	\$10,000	100%	\$10,000	After Deductible Covered in Full	\$113.29	\$288.92

**PPO (Sole Proprietor Groups)**

	Deductible* Par/Non-Par	Coinsurance Par/Non-Par	Out of Pocket* Par/Non-Par Max	Prescription Coverage Generic/Preferred/Non-Preferred	2-Tier Rates	
					Individual	Family
SPP	\$5000/\$10,000	100%/80%	\$5,000/\$12,000	After Deductible Covered in Full	\$230.80	\$588.56

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11/23/2009

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# EmblemHealth COMPREHEALTH

Employer Groups of 2+

(CompreHealth is an In-Network-Only Plan) 155-23-EM

Rates Effective 1/1/10-3/31/10

## DOWNSTATE-ONLY



	Copays				Rx Options	2-Tier Rates		4-Tier Rates			
	PCP/SPC/DEP	Hospital	ER	Amb Surgery		Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$50/\$0	\$500	\$100	\$75	LN1 LN2 LN3 LN4 LN5	\$286.46	\$733.64	\$286.46	\$547.13	\$630.21	\$847.91
2	\$30/\$50/\$0	\$1,000	\$150	\$75	LN1 LN2 LN3 LN4 LN5	\$267.77	\$685.50	\$267.77	\$511.43	\$589.09	\$792.59
3	\$25/\$40/\$0	\$500	\$100	\$50	LN1 LN2 LN3 LN4 LN5	\$309.72	\$793.17	\$309.72	\$591.57	\$681.39	\$916.77
4	\$15/\$20/\$0	\$100	\$50	\$0	LN1 LN2 LN3 LN4 LN5	\$351.34	\$899.43	\$351.34	\$671.06	\$772.95	\$1,039.97
5	\$20/\$25/\$0	\$200	\$50	\$50	LN1 LN2 LN3 LN4 LN5	\$342.17	\$875.96	\$342.17	\$653.54	\$752.76	\$1,012.82

11/20/2009

Please select an Rx Option that is listed above as available with your base plan choice and add it to your base plan rate.

Plan Option	Prescription Plan Options					2-Tier Rates			4-Tier Rates				
	Retail Copays			Retail/Brand & Mail Order Ded.*	Retail Annual Maximum	Home Delivery Copay (90 Day)	Mand./Vol. Mail Order	Ind/MCO	Family	Ind/MCO	Emp./Ch.	Emp./Sp.	Family
LN1	\$15 Generic Only			\$0	None	\$22.50	Voluntary	\$5.53	\$14.17	\$5.53	\$10.57	\$12.17	\$16.38
LN2	\$25	\$35	N/A	\$0	None	\$37.50/\$52.50	Voluntary	\$20.24	\$51.83	\$20.24	\$38.67	\$44.54	\$59.92
LN3	\$20	\$30	\$50	\$0	\$1,000	\$30/\$45/\$150	Voluntary	\$26.98	\$69.06	\$26.98	\$51.52	\$59.35	\$79.85
LN4	\$0	\$30	\$50	\$0	\$1,000	\$0/\$45/\$150	Voluntary	\$56.74	\$145.25	\$56.74	\$108.37	\$124.83	\$167.95
LN5	\$0	\$30	\$50	\$0	None	\$0/\$45/\$150	Voluntary	\$86.57	\$221.63	\$86.57	\$165.35	\$190.46	\$256.26

\* Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

11/20/2009

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