



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* 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	\$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* 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	\$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.

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



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.

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

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
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

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

* 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

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

* 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

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

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



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

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*	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	\$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*	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	\$227.49	\$580.16

* 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

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

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

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.

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