



EmblemHealth EPO IN-BALANCE

Employer Groups of 2+

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

Rates Effective 7/1/10-9/30/10**

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 FF	\$363.55	\$1,058.49	\$363.55	\$676.36	\$872.53	\$1,095.65
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S FF	\$341.78	\$995.36	\$341.78	\$636.08	\$820.29	\$1,030.34
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S FF	\$296.52	\$864.08	\$296.52	\$552.35	\$711.65	\$894.54
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S FF	\$325.13	\$947.09	\$325.13	\$605.29	\$780.34	\$980.39
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S FF	\$276.82	\$806.99	\$276.82	\$515.92	\$664.39	\$835.48
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S FF	\$262.32	\$764.90	\$262.32	\$489.07	\$629.57	\$791.93

5/3/2010

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	\$121.75	\$353.06	\$121.75	\$225.23	\$292.18	\$365.24	
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$93.00	\$269.69	\$93.00	\$172.04	\$223.20	\$279.00	
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$71.27	\$206.67	\$71.27	\$131.85	\$171.04	\$213.80	
FF	\$15 Generic/100% Brand			\$0	None	\$30 G/100% B	Voluntary	NO	\$11.97	\$32.92	\$11.97	\$22.76	\$26.35	\$35.33	
O***	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE														

5/3/2010

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

**New enrollments become effective on the 1st and the 15th of the month only.

***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.



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Rates Effective 7/1/10-9/30/10**

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 FF	\$359.66	\$1,047.22	\$359.66	\$669.17	\$863.21	\$1,083.99
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S FF	\$338.12	\$984.75	\$338.12	\$629.32	\$811.50	\$1,019.36
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S FF	\$293.32	\$854.84	\$293.32	\$546.45	\$704.00	\$884.97
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S FF	\$321.64	\$936.95	\$321.64	\$598.82	\$771.95	\$969.91
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S FF	\$273.88	\$798.45	\$273.88	\$510.47	\$657.33	\$826.64
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S FF	\$259.51	\$756.78	\$259.51	\$483.90	\$622.84	\$783.53

5/3/2010

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.
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$121.75	\$353.06	\$121.75	\$225.23	\$292.18	\$365.24
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$93.00	\$269.69	\$93.00	\$172.04	\$223.20	\$279.00
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$71.27	\$206.67	\$71.27	\$131.85	\$171.04	\$213.80
FF	\$15 Generic/100% Brand			\$0	None	\$30 G/100% B	Voluntary	NO	\$11.97	\$32.92	\$11.97	\$22.76	\$26.35	\$35.33
O***	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

5/3/2010

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

**New enrollments become effective on the 1st and the 15th of the month only.

***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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Rates Effective 7/1/10-9/30/10**

ALBANY



	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 FF	\$333.48	\$971.31	\$333.48	\$620.75	\$800.38	\$1,005.45
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S FF	\$313.49	\$913.35	\$313.49	\$583.77	\$752.42	\$945.49
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S FF	\$272.00	\$793.01	\$272.00	\$506.99	\$652.82	\$821.00
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S FF	\$298.23	\$869.07	\$298.23	\$555.52	\$715.77	\$899.69
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S FF	\$253.95	\$740.65	\$253.95	\$473.60	\$609.48	\$766.84
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S FF	\$240.61	\$701.99	\$240.61	\$448.93	\$577.50	\$726.84

5/3/2010

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
	Generic	Brand	Non-Pref.												
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$121.75	\$353.06	\$121.75	\$225.23	\$292.18	\$365.24	
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$93.00	\$269.69	\$93.00	\$172.04	\$223.20	\$279.00	
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$71.27	\$206.67	\$71.27	\$131.85	\$171.04	\$213.80	
FF	\$15 Generic/100% Brand			\$0	None	\$30 G/100% B	Voluntary	NO	\$11.97	\$32.92	\$11.97	\$22.76	\$26.35	\$35.33	
O***	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE														

5/3/2010

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

**New enrollments become effective on the 1st and the 15th of the month only.

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

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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 FF	\$342.09	\$996.27	\$342.09	\$636.67	\$821.04	\$1,031.28
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S FF	\$321.64	\$936.97	\$321.64	\$598.83	\$771.96	\$969.92
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S FF	\$279.04	\$813.41	\$279.04	\$520.02	\$669.72	\$842.12
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S FF	\$305.94	\$891.44	\$305.94	\$569.79	\$734.28	\$922.83
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S FF	\$260.50	\$759.66	\$260.50	\$485.73	\$625.23	\$786.51
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S FF	\$246.83	\$720.01	\$246.83	\$460.43	\$592.41	\$745.49

5/3/2010

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	\$121.75	\$353.06	\$121.75	\$225.23	\$292.18	\$365.24	
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$93.00	\$269.69	\$93.00	\$172.04	\$223.20	\$279.00	
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$71.27	\$206.67	\$71.27	\$131.85	\$171.04	\$213.80	
FF	\$15 Generic/100% Brand			\$0	None	\$30 G/100% B	Voluntary	NO	\$11.97	\$32.92	\$11.97	\$22.76	\$26.35	\$35.33	
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

**New enrollments become effective on the 1st and the 15th of the month only.

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5/3/2010

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Rates Effective 7/1/10-9/30/10**

SYRACUSE



	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 FF	\$321.77	\$937.34	\$321.77	\$599.08	\$772.27	\$970.31
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S FF	\$302.50	\$881.45	\$302.50	\$563.42	\$726.01	\$912.49
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S FF	\$262.45	\$765.31	\$262.45	\$489.32	\$629.90	\$792.34
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S FF	\$287.77	\$838.72	\$287.77	\$536.17	\$690.65	\$868.29
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S FF	\$245.04	\$714.81	\$245.04	\$457.12	\$588.11	\$740.12
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S FF	\$232.18	\$677.53	\$232.18	\$433.32	\$557.26	\$701.54

5/3/2010

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	\$121.75	\$353.06	\$121.75	\$225.23	\$292.18	\$365.24
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$93.00	\$269.69	\$93.00	\$172.04	\$223.20	\$279.00
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$71.27	\$206.67	\$71.27	\$131.85	\$171.04	\$213.80
FF	\$15 Generic/100% Brand			\$0	None	\$30 G/100% B	Voluntary	NO	\$11.97	\$32.92	\$11.97	\$22.76	\$26.35	\$35.33
O***	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

5/3/2010

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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 FF	\$300.68	\$876.17	\$300.68	\$560.05	\$721.64	\$907.03
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S FF	\$282.68	\$823.97	\$282.68	\$526.75	\$678.44	\$853.04
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S FF	\$245.26	\$715.45	\$245.26	\$457.51	\$588.64	\$740.77
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S FF	\$268.91	\$784.02	\$268.91	\$501.28	\$645.39	\$811.72
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S FF	\$229.01	\$668.34	\$229.01	\$427.46	\$549.65	\$692.04
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S FF	\$216.97	\$633.42	\$216.97	\$405.18	\$520.75	\$655.91

5/3/2010

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	\$121.75	\$353.06	\$121.75	\$225.23	\$292.18	\$365.24
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$93.00	\$269.69	\$93.00	\$172.04	\$223.20	\$279.00
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$71.27	\$206.67	\$71.27	\$131.85	\$171.04	\$213.80
FF	\$15 Generic/100% Brand			\$0	None	\$30 G/100% B	Voluntary	NO	\$11.97	\$32.92	\$11.97	\$22.76	\$26.35	\$35.33
O***	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

5/3/2010

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Rates Effective 7/1/10-9/30/10**

BUFFALO



	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 FF	\$302.45	\$881.33	\$302.45	\$563.34	\$725.92	\$912.37
2	\$30/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	P R S FF	\$284.37	\$828.88	\$284.37	\$529.89	\$682.52	\$858.12
3	\$30/\$0	\$2,000/\$6,000	80%	\$2,000/\$6,000	P R S FF	\$246.71	\$719.67	\$246.71	\$460.21	\$592.13	\$745.14
4	\$40/\$0	\$1,000/\$3,000	90%	\$500/\$1,500	O P R S FF	\$270.53	\$788.74	\$270.53	\$504.28	\$649.29	\$816.59
5	\$40/\$0	\$2,000/\$6,000	80%	\$3,000/\$9,000	P R S FF	\$230.37	\$672.28	\$230.37	\$429.99	\$552.92	\$696.12
6	\$40/\$0	\$2,000/\$6,000	80%	\$10,000/\$30,000	P R S FF	\$218.26	\$637.15	\$218.26	\$407.57	\$523.84	\$659.78

5/3/2010

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.
P	\$0	\$30	\$50	\$0	None	\$0/\$60/\$100	Voluntary	NO	\$121.75	\$353.06	\$121.75	\$225.23	\$292.18	\$365.24
R	\$0	\$30	\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	NO	\$93.00	\$269.69	\$93.00	\$172.04	\$223.20	\$279.00
S	\$0	\$30	\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	NO	\$71.27	\$206.67	\$71.27	\$131.85	\$171.04	\$213.80
FF	\$15 Generic/100% Brand			\$0	None	\$30 G/100% B	Voluntary	NO	\$11.97	\$32.92	\$11.97	\$22.76	\$26.35	\$35.33
O***	DISCOUNT PHARMACY PROGRAM, INCLUDING DIABETIC COVERAGE - NO ADDITIONAL PREMIUM TO BASE RATE WHERE AVAILABLE													

5/3/2010

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