



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



	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	\$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.

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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

## MID-HUDSON



Copays								Rx	2-Tier Rates		4-Tier Rates				
Adults/Deps	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	\$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
	Generic	Brand	Non-Pref.											
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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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

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Employer Groups of 2+

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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

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Employer Groups of 2+

PLH SGC 991/PLH SGC 990-C

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

## SYRACUSE



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	\$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
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 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
<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. 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

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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

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