



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

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
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

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11/17/2009

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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
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

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.	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
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

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