



EmblemHealth

PPO Employer Groups of 2+

PLH SGC 976-2/PLH SGC 976-G

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

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	\$569.72	\$1,656.38	\$569.72	\$1,057.76	\$1,367.33	\$1,714.14	
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$591.54	\$1,719.66	\$591.54	\$1,098.12	\$1,419.70	\$1,779.60	
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$557.32	\$1,620.44	\$557.32	\$1,034.83	\$1,337.59	\$1,676.97	
4	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$647.21	\$1,881.11	\$647.21	\$1,201.12	\$1,553.31	\$1,946.61	
5	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$624.87	\$1,816.35	\$624.87	\$1,159.81	\$1,499.71	\$1,879.62	
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000							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
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$139.82	\$405.50	\$139.82	\$258.69	\$335.59	\$419.49
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$131.17	\$380.37	\$131.17	\$242.65	\$314.78	\$393.49
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$106.31	\$308.28	\$106.31	\$196.67	\$255.13	\$318.91
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$81.21	\$235.49	\$81.21	\$150.23	\$194.88	\$243.61
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$74.81	\$216.96	\$74.81	\$138.40	\$179.55	\$224.43

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

5/3/2010

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

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 **7/1/10-9/30/10****
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	\$563.69	\$1,638.94	\$563.69	\$1,046.64	\$1,352.89	\$1,696.09
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$579.70	\$1,685.31	\$579.70	\$1,076.23	\$1,391.29	\$1,744.08
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$551.45	\$1,603.39	\$551.45	\$1,023.97	\$1,323.49	\$1,659.34
4	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$625.29	\$1,817.55	\$625.29	\$1,160.58	\$1,500.73	\$1,880.88
5	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$603.72	\$1,755.00	\$603.72	\$1,120.67	\$1,448.96	\$1,816.17
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000							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
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$139.82	\$405.50	\$139.82	\$258.69	\$335.59	\$419.49
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$131.17	\$380.37	\$131.17	\$242.65	\$314.78	\$393.49
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$106.31	\$308.28	\$106.31	\$196.67	\$255.13	\$318.91
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$81.21	\$235.49	\$81.21	\$150.23	\$194.88	\$243.61
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$74.81	\$216.96	\$74.81	\$138.40	\$179.55	\$224.43

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5/3/2010

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EmblemHealth
PPO Employer Groups of 2+
 PLH SGC 976-2/PLH SGC 976-G
 Rates Effective **7/1/10-9/30/10****
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	\$493.07	\$1,434.11	\$493.07	\$915.97	\$1,183.39	\$1,484.22		
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$507.04	\$1,474.60	\$507.04	\$941.81	\$1,216.90	\$1,526.10		
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$482.35	\$1,403.01	\$482.35	\$896.14	\$1,157.65	\$1,452.05		
4	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$547.35	\$1,591.51	\$547.35	\$1,016.39	\$1,313.65	\$1,647.05		
5	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$528.52	\$1,536.91	\$528.52	\$981.56	\$1,268.47	\$1,590.57		
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000									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
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$139.82	\$405.50	\$139.82	\$258.69	\$335.59	\$419.49
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$131.17	\$380.37	\$131.17	\$242.65	\$314.78	\$393.49
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$106.31	\$308.28	\$106.31	\$196.67	\$255.13	\$318.91
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$81.21	\$235.49	\$81.21	\$150.23	\$194.88	\$243.61
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$74.81	\$216.96	\$74.81	\$138.40	\$179.55	\$224.43

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5/3/2010

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PPO Employer Groups of 2+
 PLH SGC 976-2/PLH SGC 976-G
 Rates Effective **7/1/10-9/30/10****
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	\$497.40	\$1,446.66	\$497.40	\$923.99	\$1,193.78	\$1,497.20
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$511.52	\$1,487.61	\$511.52	\$950.11	\$1,227.66	\$1,539.55
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$486.60	\$1,415.35	\$486.60	\$904.01	\$1,167.87	\$1,464.81
4	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$551.72	\$1,604.21	\$551.72	\$1,024.49	\$1,324.17	\$1,660.18
5	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$532.74	\$1,549.14	\$532.74	\$989.36	\$1,278.59	\$1,603.21
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000							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.											
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$139.82	\$405.50	\$139.82	\$258.69	\$335.59	\$419.49
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$131.17	\$380.37	\$131.17	\$242.65	\$314.78	\$393.49
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$106.31	\$308.28	\$106.31	\$196.67	\$255.13	\$318.91
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$81.21	\$235.49	\$81.21	\$150.23	\$194.88	\$243.61
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$74.81	\$216.96	\$74.81	\$138.40	\$179.55	\$224.43

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5/3/2010

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EmblemHealth
PPO Employer Groups of 2+
 PLH SGC 976-2/PLH SGC 976-G
 Rates Effective **7/1/10-9/30/10****
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	\$464.84	\$1,352.24	\$464.84	\$863.74	\$1,115.64	\$1,399.52
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$478.01	\$1,390.42	\$478.01	\$888.11	\$1,147.23	\$1,439.03
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$454.75	\$1,322.98	\$454.75	\$845.08	\$1,091.41	\$1,369.25
4	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$516.01	\$1,500.60	\$516.01	\$958.40	\$1,238.43	\$1,553.01
5	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$498.25	\$1,449.12	\$498.25	\$925.55	\$1,195.81	\$1,499.74
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000							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
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$139.82	\$405.50	\$139.82	\$258.69	\$335.59	\$419.49
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$131.17	\$380.37	\$131.17	\$242.65	\$314.78	\$393.49
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$106.31	\$308.28	\$106.31	\$196.67	\$255.13	\$318.91
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$81.21	\$235.49	\$81.21	\$150.23	\$194.88	\$243.61
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$74.81	\$216.96	\$74.81	\$138.40	\$179.55	\$224.43

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5/3/2010

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 PLH SGC 976-2/PLH SGC 976-G
 Rates Effective **7/1/10-9/30/10****
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	\$443.41	\$1,290.08	\$443.41	\$824.10	\$1,064.20	\$1,335.21
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$455.95	\$1,326.47	\$455.95	\$847.32	\$1,094.32	\$1,372.86
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$433.77	\$1,262.13	\$433.77	\$806.27	\$1,041.07	\$1,306.31
4	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$492.18	\$1,431.52	\$492.18	\$914.32	\$1,181.25	\$1,481.54
5	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$475.24	\$1,382.38	\$475.24	\$882.99	\$1,140.59	\$1,430.71
In-Network Annual Maximum: Unlimited								Out-of-Network Annual Maximum: \$1,000,000						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
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$139.82	\$405.50	\$139.82	\$258.69	\$335.59	\$419.49
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$131.17	\$380.37	\$131.17	\$242.65	\$314.78	\$393.49
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$106.31	\$308.28	\$106.31	\$196.67	\$255.13	\$318.91
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$81.21	\$235.49	\$81.21	\$150.23	\$194.88	\$243.61
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$74.81	\$216.96	\$74.81	\$138.40	\$179.55	\$224.43

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 Rates Effective **7/1/10-9/30/10****
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	\$448.78	\$1,305.63	\$448.78	\$834.02	\$1,077.07	\$1,351.32
2	\$40/\$0	\$1,000/\$3,000	\$100	50%/50%	\$1,000	\$500	\$2,500/\$7,500	AA BB CC DD EE	\$461.48	\$1,342.49	\$461.48	\$857.53	\$1,107.56	\$1,389.43
3	\$40/\$0	\$3,000/\$9,000	\$100	50%/50%	\$500/day x 3	\$500	\$5,000/\$15,000	AA BB CC DD EE	\$439.03	\$1,277.39	\$439.03	\$816.01	\$1,053.70	\$1,322.10
4	\$30/\$0	\$1,000/\$3,000	\$100	70%/30%	\$500	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$498.15	\$1,448.84	\$498.15	\$925.37	\$1,195.58	\$1,499.45
5	\$30/\$0	\$2,000/\$6,000	\$100	70%/30%	\$300/day x 5	\$250	\$3,000/\$9,000	AA BB CC DD EE	\$480.99	\$1,399.08	\$480.99	\$893.64	\$1,154.41	\$1,447.98
In-Network Annual Maximum: Unlimited							Out-of-Network Annual Maximum: \$1,000,000							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
AA	\$0	\$25	\$50	\$0	None	\$0/\$50/\$100	Voluntary	NO	\$139.82	\$405.50	\$139.82	\$258.69	\$335.59	\$419.49
BB	\$0	\$25	\$50	\$100	None	\$0/\$50/\$100	Voluntary	NO	\$131.17	\$380.37	\$131.17	\$242.65	\$314.78	\$393.49
CC	\$0	\$25	\$50	\$50	\$3,000	\$0/\$50/\$100	Voluntary	NO	\$106.31	\$308.28	\$106.31	\$196.67	\$255.13	\$318.91
DD	\$0	\$25	\$50	\$50	\$1,000	\$0/\$50/\$100	Voluntary	NO	\$81.21	\$235.49	\$81.21	\$150.23	\$194.88	\$243.61
EE	\$0	\$25	\$50	\$50	\$750	\$0/\$50/\$100	Voluntary	NO	\$74.81	\$216.96	\$74.81	\$138.40	\$179.55	\$224.43

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

5/3/2010

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

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.