



# EmblemHealth

## EPO/In-Balance/Consumer-Direct/PPO/Rx Plans

### DOWNSTATE



1st Quarter 2012 Rates Effective 1/1/12-3/31/12

#### EPO (In-Network Only) PLH EPO-100A/PLH EPO 100U

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Inpatient Hospital	Ambulatory Surgery	Skilled Nursing	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/day x 3	\$750	\$200/day x 3	\$200	EH8 EH10 FF O	\$485.62	\$1,413.43	\$485.62	\$903.05	\$1,165.49	\$1,511.45
2	\$40/\$0	\$1,000	\$750	\$200/day x 3	\$100	EH8 EH10 FF O	\$439.11	\$1,278.63	\$439.11	\$817.03	\$1,053.89	\$1,323.52

#### EPO IN-BALANCE (In-Network Only) PLH EPO-995/PLH EPO 994C

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Deductible Ind/Family	Coinsurance	Coins. Max Ind/Family	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$2,500/\$7,500	80%	\$2,000/\$6,000	\$200	EH8 EH10 FF O	\$360.93	\$1,051.83	\$360.93	\$672.37	\$866.23	\$1,124.91
2	\$50/\$0	\$2,500/\$7,500	70%	\$2,500/\$7,500	\$200	EH8 EH10 FF O	\$347.29	\$1,012.27	\$347.29	\$647.13	\$833.48	\$1,082.61

#### PPO (In & Out-of-Network) PLH SGC 976-2/PLH SGC 976-G

	Copays						Rx	4-Tier Rates				
	Office Visit Adults/Depts	Inpatient Hospital	Out of Network Deductible	Ambulatory Surgery	Out of Network Coinsurance	Out-of-Ntwk Coins. Max	ER	Available Options	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$500/day x 3	\$5,000/\$15,000	\$300	70%/30%	\$3,000/\$9,000	\$200	EH1 EH3	\$687.41	\$1,276.35	\$1,649.79	\$2,136.99

NOTE: Out-of-Network Reimbursement is at the 140th-%ile of RBRVS\*\*\*

#### CONSUMER DIRECT EPO - SOLE PROPRIETORS (In-Network Only) PLH SGC 997/PLH SGC 1000

	Copays			Rx	2-Tier Rates	
	Deductible Ind/Family	Coinsurance	Out-of-Pocket Maximum Ind/Family	Generic/Preferred/Non-Preferred	Ind.	Family
SPE1	\$5,800/\$11,600	100%	\$5,800/\$11,600	Covered in Full After Deductible	\$335.00	\$971.50
SPE2	\$10,000/\$20,000	100%	\$10,000/\$20,000	Covered in Full After Deductible	\$231.47	\$671.30

#### Prescription Options

	Retail Copay/Coins	Deductible*	Retail Annual	Home Delivery Copay/Coinsurance	Home Delivery Mandatory/	2-Tier Rates		4-Tier Rates			
	Tier1/Tier2/Tier3	Retail & Mail	Threshold	Tier1/Tier2/Tier3	Voluntary	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
EH1	\$10/\$25/\$50	\$50	N/A	\$20 / \$62.50 / \$125	Voluntary	N/A	N/A	\$199.83	\$369.67	\$479.58	\$619.44
EH3	\$10/\$35/\$70	\$100	N/A	\$20 / \$87.50 / \$175	Voluntary	N/A	N/A	\$176.09	\$325.78	\$422.64	\$545.91
EH8	\$15/\$35/\$75	\$100	N/A	\$30 / \$87.50 / \$187.50	Voluntary	\$109.05	\$316.27	\$109.05	\$201.75	\$261.74	\$338.07
EH10	\$10/\$30/\$50	\$50	\$1,000 then 50%	\$20 / \$75 / \$125	Voluntary	\$97.38	\$282.39	\$97.38	\$180.15	\$233.71	\$301.87
FF**	\$15 generic	\$0	None	\$30 generic/100% brand	Voluntary	\$15.17	\$41.74	\$15.17	\$28.86	\$33.42	\$44.79
O	Discount Pharmacy Program, including diabetic coverage - No additional premium applies										

\* Deductible applies to Tier 2 and Tier 3 drugs only \*\* Single source generic does not apply to Rx Option FF \*\*\*Resouce-Based Relative Value Scale

**Rates are subject to EmblemHealth and NYS Insurance Department Approval**

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# EmblemHealth

## EPO/In-Balance/Consumer-Direct/PPO/Rx Plans

### MID-HUDSON



1st Quarter 2012 Rates Effective 1/1/12-3/31/12

#### EPO (In-Network Only) PLH EPO-100A/PLH EPO 100U

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Inpatient Hospital	Ambulatory Surgery	Skilled Nursing	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/day x 3	\$750	\$200/day x 3	\$200	EH8 EH10 FF O	\$480.77	\$1,399.37	\$480.77	\$894.08	\$1,153.85	\$1,496.42
2	\$40/\$0	\$1,000	\$750	\$200/day x 3	\$100	EH8 EH10 FF O	\$435.93	\$1,269.32	\$435.93	\$811.09	\$1,046.23	\$1,313.93

#### EPO IN-BALANCE (In-Network Only) PLH EPO-995/PLH EPO 994C

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Deductible Ind/Family	Coinsurance	Coins. Max Ind/Family	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$2,500/\$7,500	80%	\$2,000/\$6,000	\$200	EH8 EH10 FF O	\$357.33	\$1,041.38	\$357.33	\$665.71	\$857.60	\$1,113.75
2	\$50/\$0	\$2,500/\$7,500	70%	\$2,500/\$7,500	\$200	EH8 EH10 FF O	\$343.82	\$1,002.23	\$343.82	\$640.71	\$825.18	\$1,071.87

#### PPO (In & Out-of-Network) PLH SGC 976-2/PLH SGC 976-G

	Copays						Rx	4-Tier Rates				
	Office Visit Adults/Depts	Inpatient Hospital	Out of Network Deductible	Ambulatory Surgery	Out of Network Coinsurance	Out-of-Ntwk Coins. Max	ER	Available Options	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$500/day x 3	\$5,000/\$15,000	\$300	70%/30%	\$3,000/\$9,000	\$200	EH1 EH3	\$680.55	\$1,263.66	\$1,633.32	\$2,115.72

NOTE: Out-of-Network Reimbursement is at the 140th-%ile of RBRVS\*\*\*

#### CONSUMER DIRECT EPO - SOLE PROPRIETORS (In-Network Only) PLH SGC 997/PLH SGC 1000

	Copays			Rx	2-Tier Rates	
	Deductible Ind/Family	Coinsurance	Out-of-Pocket Maximum Ind/Family	Generic/Preferred/Non-Preferred	Ind.	Family
SPE1	\$5,800/\$11,600	100%	\$5,800/\$11,600	Covered in Full After Deductible	\$338.36	\$981.32
SPE2	\$10,000/\$20,000	100%	\$10,000/\$20,000	Covered in Full After Deductible	\$233.78	\$677.94

#### Prescription Options

	Retail Copay/Coins	Deductible*	Retail Annual	Home Delivery Copay/Coinsurance	Home Delivery Mandatory/	2-Tier Rates		4-Tier Rates			
	Tier1/Tier2/Tier3	Retail & Mail	Threshold	Tier1/Tier2/Tier3	Voluntary	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
EH1	\$10/\$25/\$50	\$50	N/A	\$20 / \$62.50 / \$125	Voluntary	N/A	N/A	\$199.83	\$369.67	\$479.58	\$619.44
EH3	\$10/\$35/\$70	\$100	N/A	\$20 / \$87.50 / \$175	Voluntary	N/A	N/A	\$176.09	\$325.78	\$422.64	\$545.91
EH8	\$15/\$35/\$75	\$100	N/A	\$30 / \$87.50 / \$187.50	Voluntary	\$109.05	\$316.27	\$109.05	\$201.75	\$261.74	\$338.07
EH10	\$10/\$30/\$50	\$50	\$1,000 then 50%	\$20 / \$75 / \$125	Voluntary	\$97.38	\$282.39	\$97.38	\$180.15	\$233.71	\$301.87
FF**	\$15 generic	\$0	None	\$30 generic/100% brand	Voluntary	\$15.17	\$41.74	\$15.17	\$28.86	\$33.42	\$44.79
O	Discount Pharmacy Program, including diabetic coverage - No additional premium applies										

\* Deductible applies to Tier 2 and Tier 3 drugs only \*\* Single source generic does not apply to Rx Option FF \*\*\*Resouce-Based Relative Value Scale

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# EmblemHealth

## EPO/In-Balance/Consumer-Direct/PPO/Rx Plans

### ALBANY



1st Quarter 2012 Rates Effective 1/1/12-3/31/12

#### EPO (In-Network Only) PLH EPO-100A/PLH EPO 100U

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Inpatient Hospital	Ambulatory Surgery	Skilled Nursing	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/day x 3	\$750	\$200/day x 3	\$200	EH8 EH10 FF O	\$446.86	\$1,301.04	\$446.86	\$831.33	\$1,072.46	\$1,391.29
2	\$40/\$0	\$1,000	\$750	\$200/day x 3	\$100	EH8 EH10 FF O	\$403.44	\$1,175.09	\$403.44	\$750.99	\$968.21	\$1,216.42

#### EPO IN-BALANCE (In-Network Only) PLH EPO-995/PLH EPO 994C

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Deductible Ind/Family	Coinsurance	Coins. Max Ind/Family	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$2,500/\$7,500	80%	\$2,000/\$6,000	\$200	EH8 EH10 FF O	\$332.14	\$968.32	\$332.14	\$619.09	\$797.12	\$1,035.64
2	\$50/\$0	\$2,500/\$7,500	70%	\$2,500/\$7,500	\$200	EH8 EH10 FF O	\$319.58	\$931.92	\$319.58	\$595.88	\$767.00	\$996.72

#### PPO (In & Out-of-Network) PLH SGC 976-2/PLH SGC 976-G

	Copays						Rx	4-Tier Rates				
	Office Visit Adults/Depts	Inpatient Hospital	Out of Network Deductible	Ambulatory Surgery	Out of Network Coinsurance	Out-of-Ntwk Coins. Max	ER	Available Options	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$500/day x 3	\$5,000/\$15,000	\$300	70%/30%	\$3,000/\$9,000	\$200	EH1 EH3	\$632.50	\$1,174.75	\$1,517.99	\$1,966.76

NOTE: Out-of-Network Reimbursement is at the 140th-%ile of RBRVS\*\*\*

#### CONSUMER DIRECT EPO - SOLE PROPRIETORS (In-Network Only) PLH SGC 997/PLH SGC 1000

	Copays			Rx	2-Tier Rates	
	Deductible Ind/Family	Coinsurance	Out-of-Pocket Maximum Ind/Family	Generic/Preferred/Non-Preferred	Ind.	Family
SPE1	\$5,800/\$11,600	100%	\$5,800/\$11,600	Covered in Full After Deductible	\$317.00	\$919.30
SPE2	\$10,000/\$20,000	100%	\$10,000/\$20,000	Covered in Full After Deductible	\$219.03	\$635.18

#### Prescription Options

	Retail Copay/Coins Tier1/Tier2/Tier3	Deductible* Retail & Mail	Retail Annual Threshold	Home Delivery Copay/Coinsurance Tier1/Tier2/Tier3	Home Delivery Mandatory/ Voluntary	2-Tier Rates		4-Tier Rates			
						Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
EH1	\$10/\$25/\$50	\$50	N/A	\$20 / \$62.50 / \$125	Voluntary	N/A	N/A	\$199.83	\$369.67	\$479.58	\$619.44
EH3	\$10/\$35/\$70	\$100	N/A	\$20 / \$87.50 / \$175	Voluntary	N/A	N/A	\$176.09	\$325.78	\$422.64	\$545.91
EH8	\$15/\$35/\$75	\$100	N/A	\$30 / \$87.50 / \$187.50	Voluntary	\$109.05	\$316.27	\$109.05	\$201.75	\$261.74	\$338.07
EH10	\$10/\$30/\$50	\$50	\$1,000 then 50%	\$20 / \$75 / \$125	Voluntary	\$97.38	\$282.39	\$97.38	\$180.15	\$233.71	\$301.87
FF**	\$15 generic	\$0	None	\$30 generic/100% brand	Voluntary	\$15.17	\$41.74	\$15.17	\$28.86	\$33.42	\$44.79
O	Discount Pharmacy Program, including diabetic coverage - No additional premium applies										

\* Deductible applies to Tier 2 and Tier 3 drugs only \*\* Single source generic does not apply to Rx Option FF \*\*\*Resouce-Based Relative Value Scale

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# EmblemHealth

## EPO/In-Balance/Consumer-Direct/PPO/Rx Plans

### UTICA/WATERTOWN

1st Quarter 2012 Rates Effective 1/1/12-3/31/12



### EPO (In-Network Only) PLH EPO-100A/PLH EPO 100U

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Inpatient Hospital	Ambulatory Surgery	Skilled Nursing	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/day x 3	\$750	\$200/day x 3	\$200	EH8 EH10 FF O	\$451.70	\$1,315.06	\$451.70	\$840.28	\$1,084.07	\$1,406.28
2	\$40/\$0	\$1,000	\$750	\$200/day x 3	\$100	EH8 EH10 FF O	\$407.96	\$1,188.12	\$407.96	\$759.32	\$979.04	\$1,229.93

### EPO IN-BALANCE (In-Network Only) PLH EPO-995/PLH EPO 994C

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Deductible Ind/Family	Coinsurance	Coins. Max Ind/Family	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$2,500/\$7,500	80%	\$2,000/\$6,000	\$200	EH8 EH10 FF O	\$335.73	\$978.76	\$335.73	\$625.76	\$805.77	\$1,046.80
2	\$50/\$0	\$2,500/\$7,500	70%	\$2,500/\$7,500	\$200	EH8 EH10 FF O	\$323.05	\$941.97	\$323.05	\$602.27	\$775.31	\$1,007.47

### PPO (In & Out-of-Network) PLH SGC 976-2/PLH SGC 976-G

	Copays					Rx	4-Tier Rates					
	Office Visit Adults/Depts	Inpatient Hospital	Out of Network Deductible	Ambulatory Surgery	Out of Network Coinsurance	Out-of-Ntwk Coins. Max	ER	Available Options	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$500/day x 3	\$5,000/\$15,000	\$300	70%/30%	\$3,000/\$9,000	\$200	EH1 EH3	\$639.37	\$1,187.47	\$1,534.49	\$1,988.06

NOTE: Out-of-Network Reimbursement is at the 140th-%ile of RBRVS\*\*\*

### CONSUMER DIRECT EPO - SOLE PROPRIETORS (In-Network Only) PLH SGC 997/PLH SGC 1000

	Copays			Rx	2-Tier Rates	
	Deductible Ind/Family	Coinsurance	Out-of-Pocket Maximum Ind/Family	Generic/Preferred/Non-Preferred	Ind.	Family
SPE1	\$5,800/\$11,600	100%	\$5,800/\$11,600	Covered in Full After Deductible	\$304.39	\$882.71
SPE2	\$10,000/\$20,000	100%	\$10,000/\$20,000	Covered in Full After Deductible	\$210.38	\$610.14

### Prescription Options

	Retail Copay/Coins Tier1/Tier2/Tier3	Deductible* Retail & Mail	Retail Annual Threshold	Home Delivery Copay/Coinsurance Tier1/Tier2/Tier3	Home Delivery Mandatory/ Voluntary	2-Tier Rates		4-Tier Rates			
						Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
EH1	\$10/\$25/\$50	\$50	N/A	\$20 / \$62.50 / \$125	Voluntary	N/A	N/A	\$199.83	\$369.67	\$479.58	\$619.44
EH3	\$10/\$35/\$70	\$100	N/A	\$20 / \$87.50 / \$175	Voluntary	N/A	N/A	\$176.09	\$325.78	\$422.64	\$545.91
EH8	\$15/\$35/\$75	\$100	N/A	\$30 / \$87.50 / \$187.50	Voluntary	\$109.05	\$316.27	\$109.05	\$201.75	\$261.74	\$338.07
EH10	\$10/\$30/\$50	\$50	\$1,000 then 50%	\$20 / \$75 / \$125	Voluntary	\$97.38	\$282.39	\$97.38	\$180.15	\$233.71	\$301.87
FF**	\$15 generic	\$0	None	\$30 generic/100% brand	Voluntary	\$15.17	\$41.74	\$15.17	\$28.86	\$33.42	\$44.79

Discount Pharmacy Program, including diabetic coverage - No additional premium applies

\* Deductible applies to Tier 2 and Tier 3 drugs only \*\* Single source generic does not apply to Rx Option FF \*\*\*Resource-Based Relative Value Scale

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# EmblemHealth

## EPO/In-Balance/Consumer-Direct/PPO/Rx Plans

### SYRACUSE



1st Quarter 2012 Rates Effective 1/1/12-3/31/12

#### EPO (In-Network Only) PLH EPO-100A/PLH EPO 100U

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Inpatient Hospital	Ambulatory Surgery	Skilled Nursing	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/day x 3	\$750	\$200/day x 3	\$200	EH8 EH10 FF O	\$432.32	\$1,258.86	\$432.32	\$804.43	\$1,037.56	\$1,346.19
3	\$40/\$0	\$1,000	\$750	\$200/day x 3	\$100	EH8 EH10 FF O	\$374.70	\$1,091.65	\$374.70	\$697.76	\$899.19	\$1,130.13

#### EPO IN-BALANCE (In-Network Only) PLH EPO-995/PLH EPO 994C

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Deductible Ind/Family	Coinsurance	Coins. Max Ind/Family	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$2,500/\$7,500	80%	\$2,000/\$6,000	\$200	EH8 EH10 FF O	\$321.34	\$937.00	\$321.34	\$599.12	\$771.21	\$1,002.16
2	\$50/\$0	\$2,500/\$7,500	70%	\$2,500/\$7,500	\$200	EH8 EH10 FF O	\$309.20	\$901.80	\$309.20	\$576.65	\$742.08	\$964.53

#### PPO (In & Out-of-Network) PLH SGC 976-2/PLH SGC 976-G

	Copays						Rx	4-Tier Rates				
	Office Visit Adults/Depts	Inpatient Hospital	Out of Network Deductible	Ambulatory Surgery	Out of Network Coinsurance	Out-of-Ntwk Coins. Max	ER	Available Options	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$500/day x 3	\$5,000/\$15,000	\$300	70%/30%	\$3,000/\$9,000	\$200	EH1 EH3	\$611.91	\$1,136.69	\$1,468.59	\$1,902.95

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#### CONSUMER DIRECT EPO - SOLE PROPRIETORS (In-Network Only) PLH SGC 997/PLH SGC 1000

	Copays			Rx	2-Tier Rates	
	Deductible Ind/Family	Coinsurance	Out-of-Pocket Maximum Ind/Family	Generic/Preferred/Non-Preferred	Ind.	Family
SPE1	\$5,800/\$11,600	100%	\$5,800/\$11,600	Covered in Full After Deductible	\$305.43	\$885.68
SPE2	\$10,000/\$20,000	100%	\$10,000/\$20,000	Covered in Full After Deductible	\$210.92	\$611.69

#### Prescription Options

	Retail Copay/Coins	Deductible*	Retail Annual	Home Delivery Copay/Coinsurance	Home Delivery Mandatory/	2-Tier Rates		4-Tier Rates			
	Tier1/Tier2/Tier3	Retail & Mail	Threshold	Tier1/Tier2/Tier3	Voluntary	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
EH1	\$10/\$25/\$50	\$50	N/A	\$20 / \$62.50 / \$125	Voluntary	N/A	N/A	\$199.83	\$369.67	\$479.58	\$619.44
EH3	\$10/\$35/\$70	\$100	N/A	\$20 / \$87.50 / \$175	Voluntary	N/A	N/A	\$176.09	\$325.78	\$422.64	\$545.91
EH8	\$15/\$35/\$75	\$100	N/A	\$30 / \$87.50 / \$187.50	Voluntary	\$109.05	\$316.27	\$109.05	\$201.75	\$261.74	\$338.07
EH10	\$10/\$30/\$50	\$50	\$1,000 then 50%	\$20 / \$75 / \$125	Voluntary	\$97.38	\$282.39	\$97.38	\$180.15	\$233.71	\$301.87
FF**	\$15 generic	\$0	None	\$30 generic/100% brand	Voluntary	\$15.17	\$41.74	\$15.17	\$28.86	\$33.42	\$44.79
O	Discount Pharmacy Program, including diabetic coverage - No additional premium applies										

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### ROCHESTER



1st Quarter 2012 Rates Effective 1/1/12-3/31/12

#### EPO (In-Network Only) PLH EPO-100A/PLH EPO 100U

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Inpatient Hospital	Ambulatory Surgery	Skilled Nursing	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/day x 3	\$750	\$200/day x 3	\$200	EH8 EH10 FF O	\$403.23	\$1,174.52	\$403.23	\$750.63	\$967.78	\$1,256.06
3	\$40/\$0	\$1,000	\$750	\$200/day x 3	\$100	EH8 EH10 FF O	\$360.95	\$1,051.80	\$360.95	\$672.35	\$866.21	\$1,088.91

#### EPO IN-BALANCE (In-Network Only) PLH EPO-995/PLH EPO 994C

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Deductible Ind/Family	Coinsurance	Coins. Max Ind/Family	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$2,500/\$7,500	80%	\$2,000/\$6,000	\$200	EH8 EH10 FF O	\$299.75	\$874.41	\$299.75	\$559.18	\$719.39	\$935.25
2	\$50/\$0	\$2,500/\$7,500	70%	\$2,500/\$7,500	\$200	EH8 EH10 FF O	\$288.42	\$841.56	\$288.42	\$538.23	\$692.22	\$900.13

#### PPO (In & Out-of-Network) PLH SGC 976-2/PLH SGC 976-G

	Copays						Rx	4-Tier Rates				
	Office Visit Adults/Depts	Inpatient Hospital	Out of Network Deductible	Ambulatory Surgery	Out of Network Coinsurance	Out-of-Ntwk Coins. Max	ER	Available Options	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$500/day x 3	\$5,000/\$15,000	\$300	70%/30%	\$3,000/\$9,000	\$200	EH1 EH3	\$570.73	\$1,060.50	\$1,369.76	\$1,775.28

NOTE: Out-of-Network Reimbursement is at the 140th-%ile of RBRVS\*\*\*

#### CONSUMER DIRECT EPO - SOLE PROPRIETORS (In-Network Only) PLH SGC 997/PLH SGC 1000

	Copays			Rx	2-Tier Rates	
	Deductible Ind/Family	Coinsurance	Out-of-Pocket Maximum Ind/Family	Generic/Preferred/Non-Preferred	Ind.	Family
SPE1	\$5,800/\$11,600	100%	\$5,800/\$11,600	Covered in Full After Deductible	\$295.30	\$856.36
SPE2	\$10,000/\$20,000	100%	\$10,000/\$20,000	Covered in Full After Deductible	\$204.00	\$591.61

#### Prescription Options

	Retail Copay/Coins	Deductible*	Retail Annual	Home Delivery Copay/Coinsurance	Home Delivery Mandatory/	2-Tier Rates		4-Tier Rates			
	Tier1/Tier2/Tier3	Retail & Mail	Threshold	Tier1/Tier2/Tier3	Voluntary	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
EH1	\$10/\$25/\$50	\$50	N/A	\$20 / \$62.50 / \$125	Voluntary	N/A	N/A	\$199.83	\$369.67	\$479.58	\$619.44
EH3	\$10/\$35/\$70	\$100	N/A	\$20 / \$87.50 / \$175	Voluntary	N/A	N/A	\$176.09	\$325.78	\$422.64	\$545.91
EH8	\$15/\$35/\$75	\$100	N/A	\$30 / \$87.50 / \$187.50	Voluntary	\$109.05	\$316.27	\$109.05	\$201.75	\$261.74	\$338.07
EH10	\$10/\$30/\$50	\$50	\$1,000 then 50%	\$20 / \$75 / \$125	Voluntary	\$97.38	\$282.39	\$97.38	\$180.15	\$233.71	\$301.87
FF**	\$15 generic	\$0	None	\$30 generic/100% brand	Voluntary	\$15.17	\$41.74	\$15.17	\$28.86	\$33.42	\$44.79
O	Discount Pharmacy Program, including diabetic coverage - No additional premium applies										

\* Deductible applies to Tier 2 and Tier 3 drugs only \*\* Single source generic does not apply to Rx Option FF \*\*\*Resouce-Based Relative Value Scale

**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. **REVISED 2/2/12**



# EmblemHealth

## EPO/In-Balance/Consumer-Direct/PPO/Rx Plans

### BUFFALO



1st Quarter 2012 Rates Effective 1/1/12-3/31/12

#### EPO (In-Network Only) PLH EPO-100A/PLH EPO 100U

	Copays					Rx	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Depts	Inpatient Hospital	Ambulatory Surgery	Skilled Nursing	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$30/\$0	\$500/day x 3	\$750	\$200/day x 3	\$200	EH8 EH10 FF O	\$412.93	\$1,202.64	\$412.93	\$768.57	\$991.04	\$1,286.11
2	\$40/\$0	\$1,000	\$750	\$200/day x 3	\$100	EH8 EH10 FF O	\$362.49	\$1,056.31	\$362.49	\$675.23	\$869.96	\$1,093.57

#### EPO IN-BALANCE (In-Network Only) PLH EPO-995/PLH EPO 994C

	Copays				Rx	2-Tier Rates		4-Tier Rates				
	Office Visit Adults/Depts	Deductible Ind/Family	Coinsurance	Coins. Max Ind/Family	ER	Available Options	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$2,500/\$7,500	80%	\$2,000/\$6,000	\$200	EH8 EH10 FF O	\$306.95	\$895.28	\$306.95	\$572.50	\$736.68	\$957.56
2	\$50/\$0	\$2,500/\$7,500	70%	\$2,500/\$7,500	\$200	EH8 EH10 FF O	\$295.36	\$861.65	\$295.36	\$551.04	\$708.84	\$921.61

#### PPO (In & Out-of-Network) PLH SGC 976-2/PLH SGC 976-G

	Copays						Rx	4-Tier Rates				
	Office Visit Adults/Depts	Inpatient Hospital	Out of Network Deductible	Ambulatory Surgery	Out of Network Coinsurance	Out-of-Ntwk Coins. Max	ER	Available Options	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$40/\$0	\$500/day x 3	\$5,000/\$15,000	\$300	70%/30%	\$3,000/\$9,000	\$200	EH1 EH3	\$584.46	\$1,085.88	\$1,402.69	\$1,817.83

NOTE: Out-of-Network Reimbursement is at the 140th-%ile of RBRVS\*\*\*

#### CONSUMER DIRECT EPO - SOLE PROPRIETORS (In-Network Only) PLH SGC 997/PLH SGC 1000

	Copays			Rx	2-Tier Rates	
	Deductible Ind/Family	Coinsurance	Out-of-Pocket Maximum Ind/Family	Generic/Preferred/Non-Preferred	Ind.	Family
SPE1	\$5,800/\$11,600	100%	\$5,800/\$11,600	Covered in Full After Deductible	\$299.46	\$868.45
SPE2	\$10,000/\$20,000	100%	\$10,000/\$20,000	Covered in Full After Deductible	\$207.03	\$600.36

#### Prescription Options

	Retail Copay/Coins	Deductible*	Retail Annual Threshold	Home Delivery Copay/Coinsurance	Home Delivery Mandatory/ Voluntary	2-Tier Rates		4-Tier Rates			
	Tier1/Tier2/Tier3	Retail & Mail		Tier1/Tier2/Tier3		Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
EH1	\$10/\$25/\$50	\$50	N/A	\$20 / \$62.50 / \$125	Voluntary	N/A	N/A	\$199.83	\$369.67	\$479.58	\$619.44
EH3	\$10/\$35/\$70	\$100	N/A	\$20 / \$87.50 / \$175	Voluntary	N/A	N/A	\$176.09	\$325.78	\$422.64	\$545.91
EH8	\$15/\$35/\$75	\$100	N/A	\$30 / \$87.50 / \$187.50	Voluntary	\$109.05	\$316.27	\$109.05	\$201.75	\$261.74	\$338.07
EH10	\$10/\$30/\$50	\$50	\$1,000 then 50%	\$20 / \$75 / \$125	Voluntary	\$97.38	\$282.39	\$97.38	\$180.15	\$233.71	\$301.87
FF**	\$15 generic	\$0	None	\$30 generic/100% brand	Voluntary	\$15.17	\$41.74	\$15.17	\$28.86	\$33.42	\$44.79
O	Discount Pharmacy Program, including diabetic coverage - No additional premium applies										

\* Deductible applies to Tier 2 and Tier 3 drugs only \*\* Single source generic does not apply to Rx Option FF \*\*\*Resouce-Based Relative Value Scale

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# EmblemHealth COMPREHEALTH

**Employer Groups of 2+**

(CompreHealth is an In-Network-Only Plan) 155-23-EM

**1st Quarter Rates Effective 1/1/12-3/31/12\*\***

## DOWNSTATE-ONLY



	Copays				Rx Options	2-Tier Rates		4-Tier Rates			
	PCP/SPC/DEP	Hospital	ER	Amb Surgery		Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
<b>1</b>	\$30/\$50/\$0	\$500	\$100	\$75	LN1 LN2 LN3 LN4 LN5 LN6	\$345.29	\$1,009.06	\$345.29	\$663.05	\$811.45	\$1,075.23
<b>2</b>	\$30/\$50/\$0	\$1,000	\$150	\$75	LN1 LN2 LN3 LN4 LN5 LN6	\$309.97	\$905.84	\$309.97	\$595.23	\$728.45	\$965.25
<b>3</b>	\$25/\$40/\$0	\$500	\$100	\$50	LN1 LN2 LN3 LN4 LN5 LN6	\$375.50	\$1,097.33	\$375.50	\$721.08	\$882.43	\$1,169.31

11/14/2011

**Selection of a Primary Care Physician or OB/GYN (where applicable) is required for Enrollment**

**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.*	50% Brand Threshold	Home Delivery Copay (90 Day)	Mand./Vol. Mail Order	Ind/MCO	Family	Ind/MCO	Emp./Ch.	Emp./Sp.	Family
	Generic	Brand	Non-Pref.										
<b>LN1</b>	\$15 Generic Only			\$0	None	\$22.50	Voluntary	\$6.95	\$20.31	\$6.95	\$13.35	\$16.38	\$21.64
<b>LN2</b>	\$25	\$35	N/A	\$0	None	\$37.50/\$52.50	Voluntary	\$25.41	\$74.25	\$25.41	\$48.80	\$59.90	\$79.13
<b>LN3</b>	\$20	\$30	\$50	\$0	\$1,000/50% Coins	\$30/\$45/\$150	Voluntary	\$33.88	\$99.01	\$33.88	\$65.06	\$79.87	\$105.50
<b>LN4</b>	\$0	\$30	\$50	\$0	\$1,000/50% Coins	\$0/\$45/\$150	Voluntary	\$71.25	\$208.22	\$71.25	\$136.82	\$167.97	\$221.87
<b>LN5</b>	\$0	\$30	\$50	\$0	None	\$0/\$45/\$150	Voluntary	\$108.70	\$317.66	\$108.70	\$208.74	\$256.26	\$338.49
<b>LN6</b>	\$15	\$35	\$75	\$100 Brand Only	None	\$22.50/\$52.50/\$225	Voluntary	\$56.62	\$165.46	\$56.62	\$108.73	\$133.48	\$176.31

\* 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.

10/28/2011

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# Small Business Advantage Plan

Monthly Premiums  
Sole Proprietor Plan

441 Ninth Ave., NY, NY 10016



BASE PLAN	Region	Individual	Family
1/1/12-3/31/12	Downstate	\$1,036.41	\$3,005.61
	Mid-Hudson	\$989.32	\$2,869.02
	Albany	\$984.60	\$2,855.35
	Utica	\$857.64	\$2,487.12
	Syracuse	\$863.64	\$2,504.59
	Rochester	\$868.77	\$2,519.39
	Buffalo	\$861.10	\$2,497.13

RIDER	Region	Individual	Family
Alcohol/Substance Inpatient 1/1/12-3/31/12	Downstate	\$10.31	\$29.87
	Mid-Hudson	\$9.36	\$27.11
	Albany	\$10.15	\$29.45
	Utica	\$7.60	\$22.05
	Syracuse	\$8.92	\$25.93
	Rochester	\$9.95	\$28.87
	Buffalo	\$9.15	\$26.47

RIDER	Region	Individual	Family
Professional Nursing Services 1/1/12-3/31/12	Downstate	\$4.44	\$12.90
	Mid-Hudson	\$4.63	\$13.42
	Albany	\$5.01	\$14.52
	Utica	\$4.74	\$13.72
	Syracuse	\$4.71	\$13.69
	Rochester	\$5.22	\$15.15
	Buffalo	\$4.77	\$13.87

RIDER	Region	Individual	Family
Nursing Home Care 1/1/12-3/31/12	Downstate	\$13.06	\$37.90
	Mid-Hudson	\$11.88	\$34.44
	Albany	\$12.92	\$37.39
	Utica	\$9.66	\$28.01
	Syracuse	\$11.32	\$32.90
	Rochester	\$12.71	\$36.89
	Buffalo	\$11.65	\$33.77

In accordance with Section 4303 of the New York Insurance Law the following riders to the Small Business Advantage Program are available at an additional cost:

10/31/2011

**Hospital**

Diagnosis and Treatment of Alcoholism and Substance Abuse (PLH-5008A)  
Skilled Nursing Facility Care (PLH-5005B)

**Medical**

Professional Nursing Services (PLC-1094-B)

**Counties by Region:**

**Albany:** Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington

**Buffalo:** Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

**Downstate:** Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, Westchester

**Mid-Hudson:** Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster

**Rochester:** Livingston, Monroe, Ontario, Seneca, Wayne, Yates

**Syracuse:** Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga

**Utica:** Chenango, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida