

	Oxford Metro F Excl Metro 15/30/1000/80 NG*(EPOc)		Oxford Metro F Excl Metro 15/30 NG*(EPO)		Oxford Metro F Ease 50/500 NG*(EPO)		Oxford Liberty Lbty HMO 30/50/\$500*(HMO)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network with referrals	
Drug Card								
Prescription Card	15/35/75/Yes/50	UCR=N/A	15/35/75/Yes/50	UCR=N/A	15/35/75/Yes/50	UCR=N/A	15/35/75/Yes/100	UCR=N/A
Major Medical								
Deductible Ind/Fam	\$1,000/\$2,500		N/A		N/A		N/A	
Co-Insurance	80%		N/A		N/A		N/A	
Out-of-Pocket	\$3,000/\$7,500 (incl ded)		N/A		N/A		N/A	
Office Co-pay	\$15		\$15		\$50		\$30	
DXL/Lab Fees	Lab-no charge; DXL-50%; \$100 max		Lab-no charge; DXL-50%; \$100 max		Lab-no charge; DXL-50%; \$100 max		Lab-no charge; DXL-20% Colns up to \$100/procedure	
Specialist Co-pay	\$30		\$30		\$50		\$50	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Hospital Benefits								
Hospital In-Patient	Ded & Colns		\$150/day; \$750 max/cal yr		\$500/day; \$2,500 max/cal yr		\$500/day; \$1,000 max/conf	
Emergency Room	\$200 copay (waived if admit)		\$200 copay (waived if admit)		\$200 copay (waived if admit)		\$150 copay (waived if admit)	
Private Nursing	Not covered		Not covered		Not covered		Not covered	
Surgical Benefits								
Surgical In-Patient	Ded & Colns		\$150/day; \$750 max/cal yr		\$500/day; \$2,500 max/cal yr		\$500/day; \$1,000 max/conf	
Mental Health								
Mental Nervous In-Patient	Ded & Colns 30 days/cal yr		\$150/day; \$750 max/cal yr 30 days/cal yr		\$500/day; \$2,500 max/cal yr 30 days/cal yr		\$500/day; \$1,000 max/conf 30 days/cal yr	
Substance Abuse In-Patient	Ded & Colns Rehab-30 days/cal yr Detox-7 days/cal yr		\$150/day; \$750 max/cal yr Rehab-30 days/cal yr Detox-7 days/cal yr		\$500/day; \$2,500 max/cal yr Rehab-30 days/cal yr Detox-7 days/cal yr		\$500/day; \$1,000 max/conf Rehab-30 days/cal yr Detox-7 days/cal yr	
Single	0 x \$528.50		0 x \$674.51		0 x \$585.50		0 x \$468.11	
EE with Spouse	0 x \$1,162.70		0 x \$1,483.93		0 x \$1,288.10		0 x \$1,029.85	
EE with Child(ren)	0 x \$981.18		0 x \$1,251.30		0 x \$1,086.63		0 x \$869.57	
Family	0 x \$1,644.13		0 x \$2,096.76	Inc/(Decr)% \$0.00/NaN%	0 x \$1,820.83	Inc/(Decr)% \$0.00/NaN%	0 x \$1,457.13	Inc/(Decr)% \$0.00/NaN%
Medicare	0 \$0.00		0 \$0.00		0 \$0.00		0 \$0.00	
Monthly Cost	0 \$0.00		0 \$0.00		0 \$0.00		0 \$0.00	
Annual Cost	\$0.00		\$0.00		\$0.00		\$0.00	

	Oxford Liberty Lbty HMO 30/50/\$500*(HMO) No Rx			Oxford Freedom F HSA E 3 2850/100*(HSA) Health Savings Acct		Oxford Freedom F HSA D 6 2850/100*(HSA) Health Savings Acct		Oxford Direct F Direct 25/40/500/80 NG*(POSc)	
	In-Network			In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Drug Card									
Prescription Card	None	UCR=N/A		10/30/60/Yes after ded	UCR=N/A	10/30/60/Yes after ded	UCR=140mc%	10/30/60/Yes/100	UCR=140mc%
Major Medical									
Deductible Ind/Fam	N/A	\$2,850/\$5,700				\$2,850/\$5,700	\$2,850/\$5,700	\$500/\$1,250	\$1,000/\$2,500
Co-Insurance	N/A	N/A				N/A	70%	80%	60%
Out-of-Pocket	N/A	\$2,850/\$5,700 (incl ded)				\$2,850/\$5,700 (incl ded)	\$5,850/\$11,700 (incl ded)	\$2,500/\$6,250 (incl ded)	\$5,000/\$12,500 (incl ded)
Office Co-pay	\$30	No charge after ded				No charge after ded	Ded & Colns	\$25	Ded & Colns
DXL/Lab Fees	Lab-no charge; DXL-20% Colns up to \$100/procedure	No charge after ded				No charge after ded	Ded & Colns	Lab-no charge; DXL-50%; \$100 max	Ded & Colns
Specialist Co-pay	\$50	No charge after ded				No charge after ded	Ded & Colns	\$40	Ded & Colns
Lifetime Maximum	Unlimited	Unlimited				Unlimited	Unlimited	Unlimited	Unlimited
Hospital Benefits									
Hospital In-Patient	\$500/day; \$1,000 max/conf	No charge after ded				No charge after ded	Ded & Colns	Ded & Colns	Ded & Colns
Emergency Room	\$150 copay (waived if admit)	No charge after ded (waived if admit)				No charge after ded	Ded & Colns	\$200 copay (waived if admit)	\$200 copay (waived if admit)
Private Nursing	Not covered	Not covered				Not covered	Not covered	Not covered	Not covered
Surgical Benefits									
Surgical In-Patient	\$500/day; \$1,000 max/conf	No charge after ded				No charge after ded	Ded & Colns	Ded & Colns	Ded & Colns
Mental Health									
Mental Nervous In-Patient	\$500/day; \$1,000 max/conf 30 days/cal yr	No charge after ded 30 days/cal yr				No charge after ded 30 days/cal yr	Ded & Colns 30 days/cal yr	Ded & Colns 30 days/cal yr	Ded & Colns 30 days/cal yr
Substance Abuse In-Patient	\$500/day; \$1,000 max/conf Rehab-30 days/cal yr Detox-7 days/cal yr	No charge after ded Rehab-30 days/cal yr Detox-7 days/cal yr				No charge after ded Rehab-30 days/cal yr Detox-7 days/cal yr	In-network only	Ded & Colns Rehab-30 days/cal yr Detox-7 days/cal yr	In-network only
Single	0 x	\$375.93		0 x	\$412.07	0 x	\$520.92	0 x	\$725.72
EE with Spouse	0 x	\$827.05		0 x	\$906.55	0 x	\$1,146.02	0 x	\$1,596.59
EE with Child(ren)	0 x	\$699.04		0 x	\$765.78	0 x	\$967.37	0 x	\$1,346.26
Family	0 x	\$1,171.37	Inc/(Decr)% \$0.00/NaN%	0 x	\$1,283.20	Inc/(Decr)% \$0.00/NaN%	0 x	\$1,652.26	Inc/(Decr)% \$0.00/NaN%
Medicare	0	\$0.00		0	\$0.00		0	\$0.00	
Monthly Cost	0	\$0.00		0	\$0.00		0	\$0.00	
Annual Cost		\$0.00			\$0.00			\$0.00	

	Aetna Health Inc. OA MC 3-11 :ID 14011873*(PPOc)		Aetna Health Inc. OA EPO 1-11 :ID 14011876*(EPOc)		Aetna Health Inc. OA EPO 2-10/10 HSA Compatible :ID 14011162* (HSA) Health Savings Acct		Aetna Health Inc. NYC Community Plan 1-11 ID: 6405803*(HMO) NYC - 5 Boroughs Only	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network with referrals	
Drug Card								
Prescription Card	15/35/70/Yes	UCR=N/A	15/35/70/Yes	UCR=N/A	15/35/70/Yes/Intrgd ded	UCR=N/A	15/45/70/Yes	UCR=N/A
Major Medical								
Deductible Ind/Fam	\$1,500/\$4,500	\$3,000/\$9,000	\$1,000/\$3,000		\$2,500/\$5,000		N/A	
Co-Insurance	90% of \$15,000	70% of \$10,000	90% of \$20,000		90% of \$25,000		N/A	
Out-of-Pocket	\$3,000/\$9,000 (incl. ded)	\$6,000/\$18,000 (incl. ded)	\$3,000/\$9,000 (incl. ded)		\$5,000/\$10,000 (incl. ded)		N/A	
Office Co-pay	\$25, ded waived	70% after ded	\$30, ded waived		90% after ded		\$20 copay	
DXL/Lab Fees	90% after ded/\$50, ded waived	70% after ded	90% after ded/\$50, ded waived		90% after ded		\$40/\$0 copay	
Specialist Co-pay	\$50, ded waived	70% after ded	\$50, ded waived		90% after ded		\$40 copay	
Lifetime Maximum	Unlimited per member lifetime	Unlimited per member lifetime	Unlimited per member lifetime		Unlimited per member lifetime		Unlimited	
Hospital Benefits								
Hospital In-Patient	90% after ded	70% after ded	90% after ded		90% after ded		\$750/admission	
Emergency Room	\$150/Ded Waived	Paid as Preferred Care	\$150 copay, ded waived		90% after ded		\$150 copay	
Private Nursing	Not Covered	Not Covered	Not Covered		Not Covered		N/A	
Surgical Benefits								
Surgical In-Patient	90% after ded	70% after ded	90% after ded		90% after ded		\$750/admission	
Mental Health								
Mental Nervous In-Patient	90% after ded Bio-Unlimited d/mem/cal yr Non-Bio-limited 30d/mem/cal yr	70% after ded Bio-Unlimited d/mem/cal yr Non-Bio-limited 30d/mem/cal yr	90% after ded Bio-Unlimited d/mem/cal yr Non Bio- limited 30d/mem/cal/yr		90% after ded Bio-Unlimited d/mem/plan yr Non Bio- limited 30d/mem/plan yr		\$750/admission Bio-Unlimited d/mem/cal yr Non-Bio-limited 30d/mem/cal yr	
Substance Abuse In-Patient	90% after ded Detox-limited 7d/mem/cal yr Rehab-limited 30d/mem/cal yr	70% after ded Detox-limited 7d/mem/cal yr Rehab-limited 30d/mem/cal yr	90% after ded Detox-limited 7d/mem/cal yr Rehab- limited 30d/mem/cal yr		90% after ded Detox-limited 7d/mem/plan yr Rehab- limited 30d/mem/plan yr		\$750/admission Detox-limited 7d/cal yr Rehab-limited 30d/mem/cal yr	
Single	0 x	\$568.00	0 x	\$525.00	0 x	\$398.00	0 x	\$356.00
EE with Spouse	0 x	\$1,358.00	0 x	\$1,256.00	0 x	\$951.00	0 x	\$758.00
EE with Child(ren)	0 x	\$1,193.00	0 x	\$1,103.00	0 x	\$836.00	0 x	\$666.00
Family	0 x	\$1,846.00	0 x	\$1,707.00	0 x	\$1,293.00	0 x	\$1,084.00
Medicare	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00
Monthly Cost	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00
Annual Cost		\$0.00		\$0.00		\$0.00		\$0.00

Industry Best Rates!



EmblemHealth

EPO/In-Balance/Consumer-Direct/PPO/Rx Plan

DOWNSTATE

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



(914)207-6161

info@medicalsolutionscorp.com

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

	Copays					Rx Available Options	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Deps	Inpatient Hospital	Ambulatory Surgery	Skilled Nursing	ER		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 Available Options	2-Tier Rates		4-Tier Rates			
	Office Visit Adults/Deps	Deductible Ind/Family	Coinsurance	Coins. Max Ind/Family	ER		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%	\$2,000/\$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 Available Options	4-Tier Rates			
	Office Visit Adults/Deps	Inpatient Hospital	Out of Network Deductible	Ambulatory Surgery	Out of Network Coinsurance		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 Generic/Preferred/Non-Preferred	2-Tier Rates	
	Deductible Ind/Family	Coinsurance	Out-of-Pocket Maximum Ind/Family		Ind.	Family
SPE1	\$5,800/\$11,600	100%	\$5,800/\$11,600	Covered in Full After Deductible	\$335.00	\$971.50

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

Rates are subject to EmblemHealth and NYS Insurance Department Approval

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No exceptions, including typographical errors or omissions, will be applied or accepted. 10/31/2011



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
1	\$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
2	\$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
3	\$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
4	\$15/\$20/\$0	\$100	\$50	\$0	LN1 LN2 LN3 LN4 LN5 LN6	\$435.77	\$1,273.46	\$435.77	\$836.79	\$1,024.07	\$1,356.99
5	\$20/\$25/\$0	\$200	\$50	\$50	LN1 LN2 LN3 LN4 LN5 LN6	\$422.35	\$1,234.24	\$422.35	\$811.03	\$992.52	\$1,315.20

10/28/2011

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.

	Prescription Plan Options							2-Tier Rates		4-Tier Rates			
Plan Option	Retail Copays			Retail/Brand & Mail Order Ded.*	50% Brand Threshold	Home Delivery Copay (90 Day)	Mand./Vol. Mail Order						
	Generic	Brand	Non-Pref.					Ind/MCO	Family	Ind/MCO	Emp./Ch.	Emp./Sp.	Family
LN1	\$15 Generic Only			\$0	None	\$22.50	Voluntary	\$6.95	\$20.31	\$6.95	\$13.35	\$16.38	\$21.64
LN2	\$25	\$35	N/A	\$0	None	\$37.50/\$52.50	Voluntary	\$25.41	\$74.25	\$25.41	\$48.80	\$59.90	\$79.13
LN3	\$20	\$30	\$50	\$0	\$1,000/50% Coins	\$30/\$45/\$150	Voluntary	\$33.88	\$99.01	\$33.88	\$65.06	\$79.87	\$105.50
LN4	\$0	\$30	\$50	\$0	\$1,000/50% Coins	\$0/\$45/\$150	Voluntary	\$71.25	\$208.22	\$71.25	\$136.82	\$167.97	\$221.87
LN5	\$0	\$30	\$50	\$0	None	\$0/\$45/\$150	Voluntary	\$108.70	\$317.66	\$108.70	\$208.74	\$256.26	\$338.49
LN6	\$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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No exceptions, including typographical errors or omissions, will be applied or accepted.



HIP Health Plan of New York

An EmblemHealth Company

Groups of 2 or more

Available in the Downstate Region Only - Rates Effective: 1/1/12-3/31/12



(914)207-6161

info@medicalsolutionscorp.com

HIP SELECT EPO (In-Network Only)

	Copays & Cost-Sharing						2-Tier Rates		4-Tier Rates			
	Office Visit PCP/Specialist	Inpatient Hospital	Ambulatory Surgery	ER	In-Network Ded. & Coins.	In-Network Coins. Max	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
56	\$30/\$50	N/A	N/A	\$50	\$1,000 / 10%	\$1,000	\$376.51	\$1,111.62	\$376.51	\$723.27	\$893.33	\$1,174.07
57	\$30/\$50	N/A	N/A	\$50	\$1,000 / 10%	\$2,000	\$374.64	\$1,106.04	\$374.64	\$719.68	\$888.84	\$1,168.24
58	\$30/\$50	N/A	N/A	\$50	\$1,500 / 10%	\$1,000	\$366.40	\$1,081.46	\$366.40	\$703.86	\$869.07	\$1,142.59
59	\$30/\$50	N/A	N/A	\$50	\$1,500 / 10%	\$2,000	\$364.53	\$1,075.87	\$364.53	\$700.27	\$864.58	\$1,136.76
60	\$30/\$50	N/A	N/A	\$50	\$2,000 / 20%	\$3,500	\$348.81	\$1,028.95	\$348.81	\$670.07	\$826.84	\$1,087.80

HIP VALUE HMO (In-Network Only)

	Copays				2-Tier Rates		4-Tier Rates			
	Office Visit PCP/Specialist	Inpatient Hospital	Ambulatory Surgery	ER	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
35	\$30/\$50	\$500	\$75	\$100	\$562.78	\$1,563.58	\$562.78	\$1,080.71	\$1,322.53	\$1,752.50
36	\$30/\$50	\$1,000	\$75	\$150	\$535.35	\$1,487.36	\$535.35	\$1,028.04	\$1,258.06	\$1,667.08

HIP SELECT PPO (In & Out-of-Network)

	Copays & Cost-Sharing						2-Tier Rates		4-Tier Rates			
	Office Visit PCP/Specialist	ER	In-Network Ded. & Coins.	In-Network Coins. Max	Out-of-Network Ded. & Coins.	Out-of-Network Coins. Max	Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
57	\$30/\$50	\$50	\$1,000 / 10%	\$1,000	\$1,000 / 30%	\$3,000	\$569.69	\$1,688.07	\$569.69	\$1,094.23	\$1,356.96	\$1,775.63
58	\$30/\$50	\$50	\$1,000 / 10%	\$2,000	\$2,500 / 30%	\$3,000	\$537.30	\$1,591.43	\$537.30	\$1,032.04	\$1,279.23	\$1,674.78
59	\$30/\$50	\$50	\$1,500 / 10%	\$1,000	\$2,500 / 30%	\$5,500	\$527.58	\$1,562.43	\$527.58	\$1,013.38	\$1,255.91	\$1,644.52
61	\$30/\$50	\$50	\$1,500 / 10%	\$2,000	\$2,500 / 30%	\$5,500	\$525.37	\$1,555.84	\$525.37	\$1,009.14	\$1,250.60	\$1,637.64
62	\$30/\$50	\$50	\$2,000 / 20%	\$3,500	\$2,500 / 30%	\$6,500	\$504.82	\$1,494.52	\$504.82	\$969.67	\$1,201.28	\$1,573.64

HIP PRESCRIPTION OPTIONS

	Retail Copay	Deductible Retail & Mail	Home Delivery Copay	Home Delivery Mandatory/ Voluntary	2-Tier Rates		4-Tier Rates			
	Generic/Brand/Non-Formulary		Generic/Brand/Non-Formulary		Ind.	Family	Ind.	Emp./Ch.	Emp./Sp.	Family
1	\$20/\$30/\$50	\$50	\$30/\$45/\$75	Voluntary	\$71.87	\$214.46	\$71.87	\$138.01	\$172.49	\$223.80
2	\$15 generic	\$0	\$22.50	Voluntary	\$7.20	\$21.49	\$7.20	\$13.83	\$17.28	\$22.42
3	\$15/\$35/\$75	\$100	\$22.50/\$52.50/\$112.50	Voluntary	\$58.78	\$175.40	\$58.78	\$112.87	\$141.07	\$183.04
4	Discount Pharmacy Program, including diabetic coverage - No additional premium applies									

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