Small Group Medical Plan Options for Employers with 2-50 Eligible Employees - Effective April 1, 2011

	Option # 1 Aetna Health Inc. EPOc	Option # 2 Emblem Health EPO	Option # 3 Empire Prism EPO	Option # 4 Empire Value EPO
Monthly Rates	Individual: $ 517.00	Individual: $ 543.87	Individual: $ 504.09	Individual: $ 470.28
	EE & Spouse: $ 1,237.00	EE & Spouse: $ 1,305.28	EE & Spouse: $ 1,007.02	EE & Spouse: $ 939.40
	EE & Child(ren): $ 1,087.00	EE & Child(ren): $ 1,010.47	EE & Child(ren): $ 906.43	EE & Child(ren): $ 845.57
	Family: $ 1,682.00	Family: $ 1,637.30	Family: $ 1,509.95	Family: $ 1,408.52
Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	Referrals Required
Deductible Ind/Fam	In-Net: $1,000/$3,000	In-Net: N/A	In-Net: N/A	In-Net: N/A
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
Co-Insurance	In-Net: 90%	In-Net: N/A	In-Net: NA	In-Net: 90%
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	In-Net: Unlimited
Office Co-pay	In-Net: $25 Copay	In-Net:$40 Copay	In-Net:$35 Copay	In-Net: $30 Copay
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net:N/A
Specialist Co-pay	In-Net: $50 Copay	In-Net: $40 Copay	$50 Copay	$50 Copay
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
DXL/Lab Fees	In-Net: $50 Copay	In-Net:$40 Copay	In-Net: $35	In-Net:No Charge
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
Hospital In-Patient	In-Net: Ded & Coins	$1,000 Copay	$500 copay per admis; $3750 max/cal yr	In-Net: Ded & Coins
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
Hospital Out-Patient	In-Net: Ded & Coins	$750 Copay	$300 Copay	In-Net: Ded & Coins
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
Emergency Room	Ded & Coins.	$100 Copay	$150 Copay	$150 Copay
Private Nursing	Not Covered	Not Covered	Not Covered	Not Covered
Prescription Benefits	Generic: $15	Generic: $0	Generic: $10	Generic: $15
	Brand: $35	Brand: $30	Brand: $35	Brand: $35
	Non-Preferred: $70	Non-Preferred: $50	Non-Preferred: $70	Non-Preferred: $70
	Annual Deductible: N/A	Annual Deductible: N/A	Annual Deductible: $100	Annual Deductible: 100
	Annual Maximum: N/A	Annual Retail Maximum: N/A	Annual Maximum: N/A	Annual Maximum: N/A
Surgical In-Patient	In-Net: Ded & Coins	In-Net:$1000/admis	In-Net: No Charge	In-Net: Ded & Coins
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
Surgical Out-Patient	In-Net: Ded & Coins	In-Net: $750	$300 Copay	In-Net:Ded & Coins
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
Mental Health Inpatient	In-Net: Ded & Coins./30 days max/yr	In-Net:$1,000 Copay/30 days max/yr	In-Net:$500 copay/30 days/$3750 max/yr	In-Net: Ded & Coins
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
Mental Health Outpatient	In-Net:$50 Copay/30 visits max/yr	In-Net:$40 Copay/30 visits max/yr	In-Net:$50 Copay/20 visits max/yr	In-Net: $50 Copay/30 visits per year
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A
Chiropractic Care	In-Net:$50 Copay	In-Net: $40 Copay/$0 Dep	In-Net: $35 Copay	In-Net: $30 Copay
	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A

I have placed an "X" in the red box above the plan I have chosen.

My new premium is $__________ x 3 months (including $20.00 quarterly administrative billing fee) = $__________ and a check in this amount is enclosed.

Please accept this completed form as acknowledgment of my 2011plan election:

Signature **Date** **Print Name**