

**CONSUMER DRIVEN
RENEWAL RATES**

DATED: 5/11/10

Please visit our web site, www.LIAHealthAlliance.com, and read the benefit summaries before finalizing your selections.

RATE SHEET PLAN #	EMBLEM HEALTH				MONTHLY TWO TIER RATES		MONTHLY FOUR TIER RATES				
	COPY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
HSA HIGH DEDUCTIBLE EPO PLANS											
1	EPO 1200 90% INDEXED*										
	<u>In Network</u> Deductible \$1200/\$2400 90% Coinsurance \$5800/\$11600 OOP	No Referral	Subject to plan deductible RX \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order	National	427.61	1240.05	427.61	1026.24	791.07	1282.81	
2	EPO 2500 70%										
	<u>In Network</u> Deductible \$2500/\$5000 70% Coinsurance \$4750/\$9500 OOP	No Referral	Subject to plan deductible RX \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order	National	308.64	895.08	308.64	740.76	571.00	925.95	
3	EPO 3000 100% INDEXED*										
	<u>In Network</u> Deductible \$3,000/\$5,950 100%	No Referral	Covered in full after deductible	National	321.11	931.23	321.11	770.66	594.06	963.34	
4	EPO 5800 100% INDEXED*										
	<u>In Network</u> Deductible \$5,800/\$11,600 100%	No Referral	Covered in full after deductible	National	235.51	682.98	235.51	565.23	435.70	706.53	
5	EPO 1500 100% INDEXED*										
	<u>In Network</u> Deductible \$1500/\$3000 100%	No Referral	Covered in full after deductible	National	468.11	1357.53	468.11	1123.47	866.01	1404.34	
NON HSA HIGH DEDUCTIBLE EPO PLAN											
6	EPO 10,000 100%										
	<u>In Network</u> EPO \$10,000-Non HSA Deductible \$10,000/\$20,000 100%	No Referral	Covered in full after deductible	National	162.72	471.89	162.72	390.52	301.03	488.16	
HSA HIGH DEDUCTIBLE PPO PLANS WITH SHARED DEDUCTIBLES											
7	PPO 1200 80% INDEXED*										
	<u>In Network</u> Deductible \$1200/\$2400 80% Coinsurance \$3150/\$6300 OOP	<u>Out of Network</u> Deductible \$2200/\$4400 60% Coinsurance \$6200/\$12400 OOP	No Referral	Subject to plan deductible \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order (voluntary)	National	547.05	1586.47	547.05	1312.94	1012.05	1641.16
8	PPO 2500 100%										
	<u>In Network</u> Deductible \$2500/\$5000 100%	<u>Out of Network</u> Deductible \$5000/\$10000 80% Coinsurance \$7000/\$14000 OOP	No Referral	Covered in full after deductible	National	481.22	1395.55	481.22	1154.93	890.27	1443.67
9	PPO 2500 80%										
	<u>In Network</u> Deductible \$2500/\$5000 80% Coinsurance \$4500/\$9000 OOP	<u>Out of Network</u> Deductible \$5000/\$10000 60% Coinsurance \$9000/\$18000 OOP	No Referral	Covered in full after deductible	National	430.12	1247.34	430.12	1032.27	795.71	1290.34
10	PPO 5000 100%										
	<u>In Network</u> Deductible \$5000/\$10000 100%	<u>Out of Network</u> Deductible \$10000/\$20000 80% to \$12000/\$24000 OOP	No Referral	Covered in full after deductible	National	319.01	925.13	319.01	765.63	590.17	957.04

Rates are subject to NYS Insurance Department Approval.

NOTES:

All EMBLEM prescriptions are Voluntary Home Delivery and are NO LONGER mandatory generic
* INDEXED - deductible and out of pocket max will increase in January according to IRS guidelines.