

**TRADITIONAL
NEW BUSINESS RATES**

REVISED: 3/10/10 (2/17/10)

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			
	COPAY	Referral No Ref	RX	NET WORK						
COST SHARING										
1	CS EPO 40/1000A \$40 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	None	National	318.53	880.03	318.53	700.68	608.74	944.38
2	CS EPO 40/2000 \$40 Copay \$0 Copay Children \$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	340.76	941.16	340.76	749.69	651.02	1010.08
3	CS EPO 40/1000 \$40 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	388.09	1071.31	388.09	853.72	740.90	1149.60
4	CS EPO 30/1000 \$30 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	404.40	1116.19	404.40	889.63	771.92	1197.77
5	CS EPO 30/500 \$30 Copay \$0 Copay Children \$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	446.94	1233.20	446.94	983.18	852.70	1323.20
6	CS PPO 40/2000 <u>In Network</u> \$40 Copay - Annual Ded for hospital based services \$1000/3000 80% to \$3000/9000 OOP \$0 Copay Children <u>Out of Network</u> \$2000/6000 Annual Deductible 60% to \$6,000/18,000 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$25, Non Pref \$50 Annual Retail Max \$750 Mail Order Unlimited	National	555.66	1532.17	555.66	1222.42	1059.30	1,644.02
7	CS PPO 40/2000A <u>In Network</u> \$40 Copay - Annual Ded for hospital based services \$1000/3000 80% to \$3000/9000 OOP \$0 Copay Children <u>Out of Network</u> \$2000/6000 Annual Deductible 60% to \$6,000/18,000 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$25, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	586.40	1616.71	586.40	1290.04	1117.71	1,734.67
NON COST SHARING										
8	EPO 40/1000 \$40 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited	National	415.69	1147.23	415.69	914.46	793.35	1231.08
9	EPO 30/1000A \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	449.35	1239.78	449.35	988.47	857.30	1330.33
10	EPO 30/1000 \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	470.56	1293.13	470.56	1035.12	897.60	1392.87
11	EPO 30/500 \$30 Copay \$0 Copay Children \$500 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	511.92	1411.91	511.92	1126.15	976.17	1514.90

RATE SHEET PLAN #	EMBLEM HEALTH									
	Monthly Two Tier Rates				Monthly Four Tier Rates					
	COPAY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
NON COST SHARING (continued)										
12	PPO 25/1000 * In Network \$25 Copay \$0 Copay Children \$500 Hospital Copay Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP	No Referral	\$0/25/40	National			993.38	2185.28	1890.94	2935.16
13	PPO 30/1000 * In Network \$30 Copay \$0 Copay Children \$500 Hospital Copay Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP	No Referral	\$0 Generic \$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited	National			698.69	1537.06	1331.05	2065.89
14	PPO 30/1000A * In Network \$30 Copay \$0 Copay Children \$500 Hospital Copay Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP	No Referral	\$0 Generic \$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$3000 Mail Order Unlimited	National			723.19	1590.96	1377.61	2138.17
HMO- COMPREHEALTH										
15	HMO-30/50/1000 \$30 PCP / \$50 Specialist Copay \$0 Copay Children \$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	273.44	700.01	273.44	601.56	522.25	809.36
16	HMO-30/50/500 \$30 PCP / \$50 Specialist Copay \$0 Copay Children \$500 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	292.13	747.85	292.13	642.68	557.95	864.68
17	HMO-25/40/500A \$25 PCP / \$40 Specialist Copay \$0 Copay Children \$500 Hospital Copay	Referral	\$25 Generic/\$35 Brand	Comprehealth	330.46	845.97	330.46	727.02	631.18	978.16
18	HMO-25/40/500 \$25 PCP / \$40 Specialist Copay \$0 Copay Children \$500 Hospital Copay	Referral	\$0 Generic \$30 Brand	Comprehealth	398.46	1020.05	398.46	876.62	761.06	1179.44
19	HMO-20/25/200 \$20 PCP / \$25 Specialist Copay \$0 Copay Children \$200 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	347.84	890.47	347.84	765.23	664.36	1029.59

Rates are subject to NYS Insurance Department approval.

NOTES:

- 1) EH PPO & EPO requires 50% participation in EH products (class carve-outs allowed). The 50% participation requirement can include participation in HIP and Comprehealth.
- 2) All EH prescriptions are Voluntary Home Delivery and are NO LONGER mandatory generic.
- 3) NY Metro is a limited network.
- 4) * Non Cost Share PPO Plans #12 PPO 25/1000, #13 PPO 30/1000 and #14 PPO 30/1000A are only available with 4-Tier rates. If an employee chooses one of these plans, then 4-Tier rates must be chosen for all other employees who choose an Emblem CS PPO, EPO, HSA or Comprehealth plan.