

REVISED: 5/17/10

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	325.13	947.09	325.13	780.34	605.29	980.39
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	348.09	1013.66	348.09	835.43	647.77	1049.28
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	396.40	1153.76	396.40	951.38	737.14	1194.19
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	413.05	1202.03	413.05	991.33	767.93	1244.14
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	456.55	1328.18	456.55	1095.73	848.40	1374.65
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	574.45	1670.13	574.45	1378.71	1066.54	1728.36
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	605.95	1761.45	605.95	1454.29	1124.81	1822.84
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	426.24	1240.31	426.24	1022.98	792.35	1283.72
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	460.76	1340.40	460.76	1105.83	856.20	1387.28
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	482.49	1403.42	482.49	1157.99	896.39	1452.48
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	524.91	1526.43	524.91	1259.79	974.85	1579.72

RATE SHEET PLAN #	EMBLEM HEALTH										
	COPAY			Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)
	NON COST SHARING (continued)					Monthly Two Tier Rates		Monthly Four Tier Rates			
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			1036.00	2486.41	1920.38	3113.00
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			728.42	1748.19	1351.35	2190.22
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			753.52	1808.44	1397.79	2265.52
HMO- COMPREHEALTH											
15	HMO-30/50/1000 \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	260.37	755.08	260.37	624.88	481.68	781.12
16	HMO-30/50/500 \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	290.20	841.58	290.20	696.45	536.86	870.61
17	HMO-25/40/500A \$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$25 Generic/\$35 Brand	Comprehealth	330.17	957.50	330.17	792.41	610.80	990.51
18	HMO-25/40/500 \$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$0 Generic \$30 Brand	Comprehealth	399.87	1159.61	399.87	959.67	739.54	1199.55
19	HMO-20/25/200 \$20 PCP / \$25 Specialist Copay \$0 Copay Children	\$200 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	352.27	1021.55	352.27	845.45	659.69	1056.82

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.