

REVISED: 11/22/10 (10/13/10)

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	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)
COST SHARING											
1	CS EPO 40/1000A		No Referral	None	National	341.17	993.79	341.17	818.86	635.13	1028.74
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
2	CS EPO 40/2000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	416.98	1213.16	416.98	1000.75	775.38	1256.16
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
3	CS EPO 40/2000A		No Referral	\$15 GENERIC ONLY	National	303.35	882.17	303.35	725.52	565.84	914.67
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
4	CS EPO 40/1000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	467.67	1360.62	467.67	1122.43	869.15	1408.22
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
5	CS EPO 40/1000B		No Referral	\$15 GENERIC ONLY	National	354.04	1029.19	354.04	847.20	659.61	1066.73
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
6	CS PPO 40/2000A		No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National	660.60	1920.06	660.60	1585.42	1226.04	1986.97
	In Network \$40 Copay - Annual Ded for hospital based services \$1000/3000 80% to \$3000/9000 OOP \$0 Copay Children	Out of Network \$2000/6000 Annual Deductible 60% to \$6,000/18,000 OOP									
NON COST SHARING											
7	EPO 40/1000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	498.96	1451.38	498.96	1197.51	927.04	1502.11
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
8	EPO 40/1000A		No Referral	\$15 GENERIC ONLY	National	385.33	1119.95	385.33	922.28	717.50	1160.62
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
HMO- COMPREHEALTH											
9	HMO-30/50/1000		Referral	\$15 Generic Only	Comprehealth	267.83	824.07	267.83	642.77	535.11	867.76
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay									
10	HMO-30/50/500		Referral	\$15 Generic Only	Comprehealth	297.66	915.85	297.66	714.36	594.70	964.41
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
11	HMO-25/40/500A		Referral	\$25 Generic/\$35 Brand	Comprehealth	338.95	1042.93	338.95	813.49	677.22	1098.21
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
12	HMO-25/40/500		Referral	\$0 Generic \$30 Brand	Comprehealth	410.39	1262.73	410.39	984.93	819.95	1329.67
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
13	HMO-20/25/200		Referral	\$15 Generic Only	Comprehealth	362.67	1115.88	362.67	870.40	724.59	1175.04
	\$20 PCP / \$25 Specialist Copay \$0 Copay Children	\$200 Hospital Copay									

Rates are subject to NYS Insurance Department approval.

NOTES:

- 1) EH PPO & EPO requires 50% participation in EH products (class carve-outs allowed) and a minimum of 2 participants. Participation requirement can include participation in HIP and Comprehealth.
- 2) NY Metro (Comprehealth) is a limited network.