



**TRADITIONAL
NEW BUSINESS RATES**

1st QUARTER 2011

REVISED: 1/21/11 (12/15/10) (11/30/10) (11/22/10)

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

RATE SHEET	Monthly Two Tier Rates										Monthly Four Tier Rates		
	PLAN # EMBLEM HEALTH		COPAY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
COST SHARING													
1	CS EPO 40/1000C		\$40 Copay \$0 Copay Children	\$1000/3000 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 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	393.51	1145.50	393.51	944.41	731.91	1185.70
2	CS EPO 40/2000B												
3	CS EPO 40/2000A		\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP	No Referral	\$15 GENERIC ONLY	National	303.35	882.17	303.35	725.52	565.84	914.67
NON COST SHARING													
4	EPO 40/1000		\$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	498.96	1451.38	498.96	1197.51	927.04	1502.11
5	EPO 40/1000A												
6	EPO 40/1000B		\$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	446.51	1299.28	446.51	1071.65	830.01	1344.77
7	PPO 40/500/3000												
8	PPO 30/300/2000		<u>In Network</u> \$30 Copay \$0 Copay Children \$300 x 5 Hospital Copay; \$250 Amb.	<u>Out of Network</u> \$2000/6000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR	No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National			791.98	1900.75	1469.10	2381.15



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RATE SHEET PLAN #	EMBLEM HEALTH										
	COPAY		Referral No Ref	RX	NET WORK	Monthly Two Tier Rates		Monthly Four Tier Rates			
					EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
NON COST SHARING (continued)											
9	PPO 30/300/2000A		No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			740.06	1776.17	1373.08	2225.43
	In Network \$30 Copay \$0 Copay Children \$300 x 5 Hospital Copay; \$250 Amb.	Out of Network \$2000/6000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR									
HMO- COMPREHEALTH											
10	HMO-30/50/1000		Referral	\$15 Generic Only	Comprehealth	273.20	799.68	273.20	643.14	524.60	850.72
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay									
11	HMO-30/50/500		Referral	\$15 Generic Only	Comprehealth	303.62	888.69	303.62	714.73	583.02	945.47
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
12	HMO-25/40/500A		Referral	\$25 Generic/\$35 Brand	Comprehealth	345.82	1013.11	345.82	814.81	664.08	1076.88
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
13	HMO-25/40/500		Referral	\$0 Generic Brand \$30, Non Pref \$50	Comprehealth	419.05	1231.62	419.05	990.53	804.69	1304.89
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
14	HMO-20/25/200		Referral	\$15 Generic Only	Comprehealth	369.96	1082.69	369.96	870.77	710.37	1151.98
	\$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 & HIP products (class carve-outs allowed) and a minimum of 2 participants. Participation requirement can include participation in HIP and Comprehealth HMO.
- 2) NY Metro (Comprehealth) is a limited network.