

DATED: 3/7/11

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

RATE SHEET	Monthly										
	Two Tier Rates					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	428.92	1248.60	428.92	1029.41	797.78	1292.41
2	CS EPO 40/2000B \$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 \$3,000 threshold; 50% thereafter Mail Order Unlimited	National	421.96	1228.41	421.96	1012.71	784.92	1271.55
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	330.66	961.57	330.66	790.82	616.76	996.99
4	CS EPO 30/2000 \$30 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	473.60	1378.17	473.60	1136.63	880.46	1426.45
NON COST SHARING											
5	EPO 40/1000 \$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	543.87	1582.01	543.87	1305.28	1010.47	1637.30
6	EPO 40/1000A \$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$15 GENERIC ONLY	National	420.01	1220.76	420.01	1005.28	782.07	1265.08
7	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	486.69	1416.23	486.69	1168.09	904.71	1465.80
8	PPO 40/500/3000 In Network \$40 Copay \$0 Copay Children \$500 x 3 Hospital Copay; \$500 Amb.	Out of Network \$3000/9000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR	No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			743.58	1784.61	1379.93	2236.44
9	PPO 30/300/2000 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	No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National			863.26	2071.82	1601.32	2595.45



**TRADITIONAL
NEW BUSINESS RATES**

2nd QUARTER 2011

RATE SHEET PLAN #	EMBLEM HEALTH										
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
	Monthly Two Tier Rates					Monthly Four Tier Rates					
NON COST SHARING (continued)											
10	PPO 30/300/2000A		No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			806.66	1936.02	1496.66	2425.72
	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											
11	HMO-30/50/1000		Referral	\$15 Generic Only	Comprehealth	284.43	790.23	284.43	597.30	546.18	885.72
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay									
12	HMO-30/50/500		Referral	\$15 Generic Only	Comprehealth	316.10	878.22	316.10	663.81	606.99	984.34
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
13	HMO-25/40/500A		Referral	\$25 Generic/\$35 Brand	Comprehealth	360.04	1000.31	360.04	756.10	691.37	1121.16
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
14	HMO-25/40/500		Referral	\$0 Generic Brand \$30, Non Pref \$50	Comprehealth	436.27	1212.10	436.27	916.18	837.76	1358.54
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
15	HMO-20/25/200		Referral	\$15 Generic Only	Comprehealth	385.14	1070.04	385.14	808.80	739.58	1199.93
	\$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.