

DATED: 6/17/11

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		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
	COPAY										
COST SHARING											
1	CS EPO 40/1000A*		No Referral	None	National	386.76	1126.56	386.76	928.26	719.98	1166.18
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
2	CS EPO 40/1000C		No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	446.08	1,298.54	446.08	1,070.59	829.69	1344.11
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
3	CS EPO 40/2000B		No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$3,000 threshold; 50% thereafter Mail Order Unlimited	National	438.84	1277.55	438.84	1053.22	816.31	1322.41
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
4	CS EPO 40/2000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	472.71	1375.73	472.71	1134.46	878.96	1423.98
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
5	CS EPO 40/2000A		No Referral	\$15 GENERIC ONLY	National	343.89	1000.03	343.89	822.46	641.43	1036.87
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
6	CS EPO 40/1000*		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	530.17	1542.39	530.17	1272.39	985.26	1596.36
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
7	CS EPO 40/2500/80		No Referral	\$15 Generic Only	National	348.33	1012.91	348.33	833.11	649.64	1083.46
	\$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$4,500/13,500 OOP									
8	CS EPO 40/2500/80 A		No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	423.77	1233.87	423.77	1017.06	788.45	1319.49
	\$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$4,500/13,500 OOP									
9	CS EPO 40/1000B*		No Referral	\$15 GENERIC ONLY	National	401.35	1166.69	401.35	960.39	747.73	1209.25
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
10	CS EPO 30/2000*		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	492.55	1433.29	492.55	1182.10	915.67	1483.51
	\$30 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
11	CS EPO 30/1000*		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	512.84	1492.13	512.84	1230.79	953.21	1544.38
	\$30 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
12	CS EPO 30/500* (Available for existing enrollees only)		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	575.89	1674.91	575.89	1382.06	1069.81	1733.47
	\$30 Copay \$0 Copay Children	\$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									

RENEWAL RATES (continued)

RATE SHEET PLAN #	EMBLEM HEALTH		Referral No Ref	RX	NET WORK	Monthly Two Tier Rates		Monthly Four Tier Rates			
	COPYAY					EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
NON COST SHARING											
13	EPO 40/1000		No Referral								
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay		\$0 Generic Brand \$30, Non Pref \$50	National	565.63	1645.28	565.63	1357.49	1050.88	1702.79
14	EPO 40/1000A		No Referral								
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay		\$15 GENERIC ONLY	National	436.81	1269.58	436.81	1045.49	813.35	1315.68
15	EPO 40/1000B		No Referral								
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay		\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	506.16	1472.87	506.16	1214.81	940.89	1524.43
16	EPO 30/1000B		No Referral								
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay		\$15 GENERIC ONLY	National	477.88	1388.64	477.88	1144.04	889.32	1438.88
17	EPO 30/1000		No Referral								
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay		\$0 Generic Brand \$30, Non Pref \$50	National	606.70	1764.34	606.70	1456.04	1126.85	1825.99
18	EPO 30/500* (Available for existing enrollees)		No Referral								
	\$30 Copay \$0 Copay Children	\$500 Hospital Copay		\$0 Generic Brand \$30, Non Pref \$50	National	657.16	1910.68	657.16	1577.14	1220.17	1977.35
19	EPO 40/1000/750		No Referral								
	\$40 Copay \$0 Copay Children \$100 ER	\$1000 Hospital Copay \$750 Ambulatory		\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	512.25	1490.54	512.25	1229.44	952.16	1551.71
20	EPO 20* (existing enrollees only)		No Referral								
	\$20 Copay \$0 Copay Children	\$0 Hospital Copay		\$0/30/50	National	872.69	2535.67	872.69	2094.39	1618.90	2623.91
21	PPO 40/500/3000		No Referral								
	<u>In Network</u> \$40 Copay \$0 Copay Children \$500 x 3 Hospital Copay; \$500 Amb.	<u>Out of Network</u> \$3000/9000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR		\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			773.33	1855.99	1435.13	2325.90
22	PPO 30/300/2000		No Referral								
	<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		\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National			897.79	2154.69	1665.37	2699.26
23	PPO 30/300/2000A		No Referral								
	<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		\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			838.93	2013.46	1556.53	2522.75
24	PPO 40/500/5000		No Referral								
	<u>In Network</u> \$40 Copay \$0 Copay Children \$500 x 3 Hospital Copay	<u>Out of Network</u> \$5,000/15,000 Annual Deductible 70% to \$8,000/24,000 OOP 70th percentile UCR		\$10 Generic, \$50 ded Brand \$25, Non Pref \$50	National	820.34	2383.91	820.34	1968.81	1522.08	2548.82

RENEWAL RATES (continued)

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)											
25	PPO 25/1000* (2 tier available for existing enrollees only)										
	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	1230.16	3572.38	1230.2	2952.36	2280.2	3696.36
26	PPO 30/1000* (2 tier available for existing enrollees only)										
	In Network \$30 Copay \$0 Copay Children \$500 Hospital, \$250 Amb	Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP	No Referral	\$0 Generic \$100 Ded, Brand 25, Non Pref \$50	National	1007.37	2926.25	1007.37	2417.65	1868.1	3027.95
HMO- COMPREHEALTH											
27	HMO-30/50/1000										
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	292.95	856.10	292.95	688.43	562.55	912.25
28	HMO-30/50/1000A										
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic \$100 ded Brand \$35, Non Pref \$75	Comprehealth	339.77	992.93	339.77	798.46	652.46	1058.04
29	HMO-30/50/500										
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	325.57	951.41	325.57	765.09	625.19	1013.83
30	HMO-25/40/500A										
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$25 Generic/\$35 Brand	Comprehealth	370.84	1083.72	370.84	871.47	712.12	1154.80
31	HMO-25/40/500										
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$0 Generic \$30 Brand	Comprehealth	449.35	1313.16	449.35	1055.97	862.88	1399.28
32	HMO-20/25/200										
	\$20 PCP / \$25 Specialist Copay \$0 Copay Children	\$200 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	396.70	1159.30	396.00	932.24	761.79	1235.33

Rates are subject to NYS Insurance Department approval.

NOTES:

- 1) EH plans with prescription retail maximums are no longer available and have been replaced with corresponding plans without retail maximums. Additional plans with RX thresholds may also be selected.
- 2) NY Metro (Comprehealth) is a limited network.
- 3) Existing enrollees ONLY can renew into Plan (#17 EPO 21).
- 4) Non Cost Sharing PPO Plans (#25 PPO 25/1000 and #26 PPO 30/1000) are no longer available with 2-Tier rates EXCEPT for existing enrollees.

*THESE BENEFIT PLANS ARE ONLY AVAILABLE FOR GROUPS WHO CURRENTLY HAVE EMPLOYEES ENROLLED IN THEM.