



TRADITIONAL  
RENEWAL RATES

4th QUARTER 2011  
OCTOBER

DATED: 8/24/11

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

RATE SHEET	EMBLEM HEALTH										
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(REN)	FAMILY
PLAN #	Monthly Two Tier Rates					Monthly Four Tier Rates					
<b>COST SHARING</b>											
1	<b>CS EPO 40/2500/80</b>		No Referral	\$15 Generic Only	National	362.26	1,053.43	362.26	866.43	675.62	1126.79
	\$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$4,500/13,500 OOP									
2	<b>CS EPO 40/2500/80 A</b>		No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	440.72	1283.22	440.72	1057.70	819.98	1372.26
	\$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$4,500/13,500 OOP									
3	<b>CS EPO 40/1000A*</b>		No Referral	None	National	402.23	1171.62	402.23	965.39	748.78	1212.82
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
4	<b>CS EPO 40/1000C</b>		No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	463.93	1,350.48	463.93	1,113.41	862.87	1397.87
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
5	<b>CS EPO 40/2000B</b>		No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$3,000 threshold; 50% thereafter Mail Order Unlimited	National	456.39	1328.65	456.39	1095.35	848.97	1375.30
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
6	<b>CS EPO 40/2000</b>		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	491.62	1430.75	491.62	1179.84	914.12	1480.94
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
7	<b>CS EPO 40/2000A</b>		No Referral	\$15 GENERIC ONLY	National	357.64	1040.03	357.64	855.36	667.09	1078.34
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
8	<b>CS EPO 40/1000*</b>		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	551.38	1604.08	551.38	1323.29	1024.67	1660.21
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
9	<b>CS EPO 40/1000B*</b>		No Referral	\$15 GENERIC ONLY	National	417.40	1213.36	417.40	998.81	777.64	1257.61
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
10	<b>CS EPO 30/500* (Available for existing enrollees only)</b>		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	598.93	1741.90	598.93	1437.34	1112.60	1802.81
	\$30 Copay \$0 Copay Children	\$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									

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)	FAMILY
<b>NON COST SHARING</b>										
11	<b>EPO 40/1000</b> \$40 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	588.26	1711.09	588.26	1411.79	1092.92	1770.91
12	<b>EPO 40/1000A</b> \$40 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$15 GENERIC ONLY	National	454.28	1320.37	454.28	1087.31	845.89	1368.31
13	<b>EPO 40/1000B</b> \$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	526.41	1531.79	526.41	1263.40	978.53	1585.41
14	<b>EPO 40/1000/750</b> \$40 Copay \$0 Copay Children \$100 ER \$1000 Hospital Copay \$750 Ambulatory	No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	532.74	1550.16	532.74	1278.61	990.25	1613.78
15	<b>PPO 40/500/5000</b> <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	No Referral	\$10 Generic, \$50 ded Brand \$25, Non Pref \$50	National	853.15	2479.26	853.15	2047.56	1582.96	2650.77
16	<b>EPO 30/1000</b> \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	630.97	1834.91	630.97	1514.28	1171.92	1899.03
17	<b>EPO 30/500*</b> (Available for existing enrollees) \$30 Copay \$0 Copay Children \$500 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	683.45	1987.11	683.45	1640.22	1268.98	2056.45
18	<b>EPO 20*</b> (Available for existing enrollees only) \$20 Copay \$0 Copay Children \$0 Hospital Copay	No Referral	\$0/30/50	National	907.60	2637.1	907.60	2178.16	1683.66	2728.87



TRADITIONAL  
RENEWAL RATES (continued)

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	COPAY		Referral No Ref	RX	NET WORK	Monthly Two Tier Rates		Monthly Four Tier Rates			
PLAN #					EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
<b>HMO- COMPREHEALTH</b>											
19	<b>HMO-30/50/1000</b>										
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	301.71	881.8	301.71	709.10	579.42	939.60
20	<b>HMO-30/50/1000A</b>										
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic \$100 ded. Brand \$35, Non Pref \$75	Comprehealth	349.93	1022.72	349.93	822.42	672.02	1089.76
21	<b>HMO-30/50/500</b>										
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	335.32	979.97	335.32	788.06	643.94	1044.23
22	<b>HMO-25/40/500A</b>										
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$25 Generic/\$35 Brand	Comprehealth	381.97	1116.23	381.97	897.62	733.48	1189.43
23	<b>HMO-25/40/500</b>										
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$0 Generic \$30 Brand	Comprehealth	462.83	1352.54	462.83	1087.65	888.76	1441.23

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.

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