

DATED: 1/5/12

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		
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(REN)	FAMILY		
PLAN #	EMBLEM HEALTH												
COST SHARING													
1*	CS EPO 40/2500/80		No Referral	\$15 Generic Only	National	376.10	1,093.57	376.10	899.65	701.23	1169.70		
	\$40 Copay \$0 Copay Children \$200 ER Copay	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$2,000/6,000 OOP											
2*	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	458.31	1334.22	458.31	1099.94	852.52	1426.78		
	\$40 Copay \$0 Copay Children \$200 ER Copay	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$2,000/6,000 OOP											
3	CS EPO 40/1000A		No Referral	None	National	402.23	1171.62	402.23	965.39	748.78	1212.82		
	\$40 Copay \$0 Copay Children \$100 ER Copay	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP											
4	CS EPO 40/1000C		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 \$100 ER Copay	\$1000/3000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP											
5	CS EPO 40/2000B		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 \$100 ER Copay	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP											
6	CS EPO 40/2000		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 \$100 ER Copay	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP											
7	CS EPO 40/2000A		No Referral	\$15 GENERIC ONLY	National	357.64	1040.03	357.64	885.36	667.09	1078.34		
	\$40 Copay \$0 Copay Children \$100 ER Copay	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP											
8	CS EPO 40/1000		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 \$100 ER Copay	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP											
9	CS EPO 40/1000B		No Referral	\$15 GENERIC ONLY	National	391.80	1139.06	391.80	937.32	730.23	1180.77		
	\$40 Copay \$0 Copay Children \$100 ER Copay	\$1000/3000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP											
10	CS EPO 30/500		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 \$100 ER Copay	\$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP											

RENEWAL RATES (continued)

RATE SHEET PLAN #	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
EMBLEM HEALTH											
NON COST SHARING											
11	EPO 40/1000 \$40 Copay \$1000 Hospital Copay \$0 Copay Children \$750 Ambulatory \$100 ER Copay		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	588.26	1711.09	588.26	1411.79	1092.92	1770.91
12	EPO 40/1000A \$40 Copay \$1000 Hospital Copay \$0 Copay Children \$750 Ambulatory \$100 ER Copay		No Referral	\$15 GENERIC ONLY	National	454.28	1320.37	454.28	1087.31	845.89	1368.31
13	EPO 40/1000B \$40 Copay \$1000 Hospital Copay \$0 Copay Children \$750 Ambulatory \$100 ER 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*	EPO 40/1000/750 \$40 Copay \$1000 Hospital Copay \$0 Copay Children \$750 Ambulatory \$100 ER		No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	536.49	1561.02	536.49	1287.60	997.18	1625.39
15*	PPO 40/500/5000 <u>In Network</u> \$40 Copay \$0 Copay Children \$500x3 Hosp Copay; \$300 Ambulatory <u>Out of Network</u> \$5,000/15,000 Annual Deductible 70% to \$3,000/9,000 OOP 140% of RBRVS**		No Referral	\$10 Generic, \$50 ded Brand \$25, Non Pref \$50	National			887.24	2129.37	1646.02	2756.43
16	EPO 30/1000 \$30 Copay \$1000 Hospital Copay \$0 Copay Children \$750 Ambulatory \$100 ER Copay		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	630.97	1834.91	630.97	1514.28	1171.92	1899.03
17	EPO 30/500 \$30 Copay \$500 Hospital Copay \$0 Copay Children \$250 Ambulatory \$100 ER Copay		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	683.45	1987.11	683.45	1640.22	1268.98	2056.45

RENEWAL RATES (continued)

RATE SHEET	EMBLEM HEALTH										
	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	
	HMO- COMPREHEALTH										
18*	HMO-30/50/1000 \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay \$150 ER / \$75 Ambulatory	Referral	\$15 Generic Only	Comprehealth	316.92	926.15	316.92	744.83	608.58	986.89
19*	HMO-30/50/1000A \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay \$150 ER / \$75 Ambulatory	Referral	\$15 Generic \$35 Brand, \$75 Non Pref \$100 Brand Deductible	Comprehealth	366.59	1071.30	366.59	861.93	703.96	1141.56
20	HMO-30/50/500 \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay \$100 ER / \$75 Ambulatory	Referral	\$15 Generic Only	Comprehealth	352.24	1029.37	352.24	827.83	676.40	1096.87
21	HMO-25/40/500A \$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay \$100 ER / \$50 Ambulatory	Referral	\$25 Generic/\$35 Brand	Comprehealth	400.91	1171.58	400.91	942.33	769.88	1248.44
22	HMO-25/40/500 \$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay \$100 ER / \$50 Ambulatory	Referral	\$0 Generic \$30 Brand, \$50 Non Pref	Comprehealth	484.20	1414.99	484.20	1138.69	929.82	1507.80

Rates are subject to NYS Insurance Department approval.

NOTES:

- 1) EH members may renew into their existing plan if available.
- 2) Existing EH members who want to make changes at renewal may ONLY change into their groups other existing plans or plans that are available for new business *.
- 3) New members to EH from existing groups (coming from Easy Choice) may enroll in any of their groups existing plan(s) or plans that are available for new business*.
- 4) NY Metro (Comprehealth) is a limited network
- 5) Any changes to plan offerings must be in compliance with Emblem Small Group Underwriting Guidelines.

* Denotes plans available for New Business

** RBRVS (Resource-Based Relative Value Scale)