

**TRADITIONAL  
NEW BUSINESS RATES**

**1st QUARTER 2012**

DATED: 1/5/12

Please visit our web site, [www.LIAHealthAlliance.com](http://www.LIAHealthAlliance.com), and read the benefit summaries before finalizing your selections.

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>COST SHARING</b>											
1	<b>CS EPO 40/2500/80</b> \$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	No Referral	\$15 Generic Only	National	376.10	1,093.57	376.10	899.65	701.23	1169.70
2	<b>CS EPO 40/2500/80 A</b> \$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	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
<b>NON COST SHARING</b>											
3	<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	536.49	1561.02	536.49	1287.60	997.18	1625.39
4	<b>PPO 40/500/5000</b> <u>In Network</u> \$40 Copay \$0 Copay Children \$500 x 3 Hosp Copay/\$300 Amb	<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
<b>HMO- COMPREHEALTH</b>											
5	<b>HMO-30/50/1000</b> \$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
6	<b>HMO-30/50/1000A</b> \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay \$150 ER/\$75 Ambulatory	Referral	\$15 Generic \$100 ded Brand \$35, Non Pref \$75	Comprehealth	366.59	1071.30	366.59	861.93	703.96	1141.56

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.
- \*RBRVS (Resource-Based Relative Value Scale)