

RELEASE DATE: 12/3/09



1st QUARTER 2010

**CONSUMER DRIVEN
RENEWAL RATES**

DATED: 11/9/09

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

RATE SHEET PLAN #	Monthly Four Tier Rates								
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
1	ATLANTIS								
	POS 20/2000 HRA Option #1								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$10 Generic Brand Name \$250 ded. \$25 Copay, Max. \$2000	Atlantis	404.92	809.84	814.29	1246.34
2	POS 20/2000 HRA Option #2								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$250 Deductible \$7/30/50	Atlantis	421.11	842.22	846.85	1296.18
3	POS 20/2000 HRA Option #3								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$100 Deductible \$7/30/50	Atlantis	428.36	856.72	861.43	1318.49
4	POS 20/2000 HRA Option #4								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$7/30/50	Atlantis	435.11	870.22	875.01	1339.27

Note: The Rates contained in this document have been filed with the NYS Insurance Department but have not received final approval and therefore are subject to change.

**CONSUMER DRIVEN
RENEWAL RATES**

DATED: 11/23/09

Please visit our web site, 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
HSA HIGH DEDUCTIBLE EPO PLANS										
1	EPO 1200 90% INDEXED*									
	<u>In Network</u> Deductible \$1200/\$2400 90% Coinsurance \$5800/\$11600 OOP	No Referral	Subject to plan deductible RX \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order	National	292.30	745.39	292.30	643.09	555.37	862.30
2	EPO 2500 70%									
	<u>In Network</u> Deductible \$2500/\$5000 70% Coinsurance \$4750/\$9500 OOP	No Referral	Subject to plan deductible RX \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order	National	210.88	537.73	210.38	463.93	400.65	622.08
3	EPO 3000 100% INDEXED*									
	<u>In Network</u> Deductible \$3,000/\$5,950 100%	No Referral	Covered in full after deductible	National	242.09	617.33	242.09	532.60	460.00	714.18
4	EPO 5800 100% INDEXED*									
	<u>In Network</u> Deductible \$5,800/\$11,600 100%	No Referral	Covered in full after deductible	National	177.55	452.73	177.55	390.57	337.31	523.73
5	EPO 1500 100% INDEXED*									
	<u>In Network</u> Deductible \$1500/\$3000 100%	No Referral	Covered in full after deductible	National	319.99	815.97	319.99	703.97	607.98	943.96
NON HSA HIGH DEDUCTIBLE EPO PLAN										
6	EPO 10,000 100%									
	<u>In Network</u> EPO \$10,000-Non HSA Deductible \$10,000/\$20,000 100%	No Referral	Covered in full after deductible	National	122.67	312.82	122.67	269.88	233.08	361.88
HSA HIGH DEDUCTIBLE PPO PLANS WITH SHARED DEDUCTIBLES										
7	PPO 1200 80% INDEXED*									
	<u>In Network</u> Deductible \$1200/\$2400 80% Coinsurance \$3150/\$6300 OOP	<u>Out of Network</u> Deductible \$2200/\$4400 60% Coinsurance \$6200/\$12400 OOP	No Referral	Subject to plan deductible \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order (voluntary)	National	381.44	972.69	381.44	839.19	724.75 1125.26
8	PPO 2500 100%									
	<u>In Network</u> Deductible \$2500/\$5000 100%	<u>Out of Network</u> Deductible \$5000/\$10000 80% Coinsurance \$7000/\$14000 OOP	No Referral	Covered in full after deductible	National	335.31	855.07	335.31	737.71	637.10 989.18
9	PPO 2500 80%									
	<u>In Network</u> Deductible \$2500/\$5000 80% Coinsurance \$4500/\$9000 OOP	<u>Out of Network</u> Deductible \$5000/\$10000 60% Coinsurance \$9000/\$18000 OOP	No Referral	Covered in full after deductible	National	299.70	764.24	299.70	659.35	569.45 884.11
10	PPO 5000 100%									
	<u>In Network</u> Deductible \$5000/\$10000 100%	<u>Out of Network</u> Deductible \$10000/\$20000 80% to \$12000/\$24000 OOP	No Referral	Covered in full after deductible	National	245.23	625.34	245.23	539.51	465.93 723.43

Rates are subject to NYS Insurance Department Approval.

NOTES:

EMBLEM PPO requires 50% participation in GHI products (class carve-outs allowed).

All EMBLEM prescriptions are Voluntary Home Delivery and are NO LONGER mandatory generic

*** INDEXED - deductible and out of pocket max will increase in January according to IRS guidelines.**