

**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*										
	In Network 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%										
	In Network 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*										
	In Network 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*										
	In Network 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*										
	In Network 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%										
	In Network 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*										
	In Network Deductible \$1200/\$2400 80% Coinsurance \$3150/\$6300 OOP	Out of Network 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%										
	In Network Deductible \$2500/\$5000 100%	Out of Network 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%										
	In Network Deductible \$2500/\$5000 80% Coinsurance \$4500/\$9000 OOP	Out of Network 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%										
	In Network Deductible \$5000/\$10000 100%	Out of Network 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.**