

TRADITIONAL
RENEWAL RATES (existing groups)

1st QUARTER 2010

DATED: 11/19/09

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

RATE SHEET PLAN #	EMBLEM HEALTH (formerly GHI renewals)		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)
COST SHARING											
1	CS EPO 40/1000A \$40 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP		No Referral	None	National	294.97	756.26	294.97	648.85	563.87	874.74
2	CS EPO 40/2000 \$40 Copay \$0 Copay Children \$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	318.68	816.81	318.68	701.11	608.96	944.80
3	CS EPO 40/1000 \$40 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	362.50	928.47	362.50	797.43	692.18	1073.98
4	CS EPO 30/1000 \$30 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	377.61	967.02	377.61	830.68	720.90	1118.58
5	CS EPO 30/500 \$30 Copay \$0 Copay Children \$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	417.96	1069.84	417.96	919.40	797.52	1,237.53
6	CS PPO 30/2000 <u>In Network</u> \$30 Copay - Annual Ded for hospital based services \$1000/3000 90% to \$500/1500 OOP \$0 Copay Children <u>Out of Network</u> \$2000/6000 Annual Deductible 70% to \$1500/4500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	590.96	1511.03	590.96	1300.07	1126.25	1747.96
7	CS PPO 30/2000A <u>In Network</u> \$30 Copay - Annual Ded for hospital based services \$1000/3000 90% to \$500/1500 OOP \$0 Copay Children <u>Out of Network</u> \$2000/6000 Annual Deductible 70% to \$1500/4500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	611.56	1563.52	611.56	1345.36	1165.38	1808.68

RENEWAL RATES- (existing groups continued)

RATE SHEET PLAN #	EMBLEM HEALTH (formerly GHI renewals)				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	
NON COST SHARING											
8	EPO 40/1000 \$40 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited	National	400.38	1025.09	400.38	880.78	764.15	1185.77	
9	EPO 30/1000A \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	432.74	1107.59	432.74	951.94	825.64	1281.20	
10	EPO 30/1000 \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	453.34	1160.08	453.34	997.23	864.77	1341.92	
11	EPO 30/500 \$30 Copay \$0 Copay Children \$500 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	485.53	1242.17	485.53	1068.07	925.90	1436.87	
12	EPO 20A \$20 Copay \$0 Copay Children \$0 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	619.96	1577.25	619.96	1357.20	1175.60	1824.55	
13	EPO 20 \$20 Copay \$0 Copay Children \$0 Hospital Copay	No Referral	\$0/30/50	National	644.20	1646.72	644.20	1417.14	1227.35	1904.91	
14	PPO 25/1000 <u>In Network</u> \$25 Copay \$0 Copay Children \$500 Hospital Copay <u>Out of Network</u> \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP	No Referral	\$0/25/40	National	905.57	2313.28	905.57	1992.09	1723.98	2675.96	
15	PPO 30/1000 <u>In Network</u> \$30 Copay \$0 Copay Children \$500 Hospital Copay <u>Out of Network</u> \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$25, Non Pref \$40 Annual Retail Max \$3,000 Mail Order Unlimited	National	766.72	1959.21	766.72	1686.63	1460.18	2266.32	
16	PPO 20/500 <u>In Network</u> \$20 Copay \$0 Copay Children No Hospital Copay <u>Out of Network</u> \$500/1500 Annual Deductible 80% to \$2000/6000 OOP	No Referral	\$0/25/40	National	1130.61	2887.12	1130.61	2487.25	2151.6	3339.94	

Rates are subject to NYS Insurance Department approval.

NOTES:

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

All GHI prescriptions are Voluntary Home Delivery and are NO LONGER mandatory generic.