

RELEASED: 3/10/10

2nd QUARTER 2010



**CONSUMER DRIVEN  
NEW BUSINESS RATES**

DATED: 2/12/10

Please visit our web site, [www.LIAHealthAlliance.com](http://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  |
|                   | <b>ATLANTIS</b>   |  |                 |  |          |               |                  |                      |         |
| 1                 | <b>POS 20/2000 HRA Option #1</b>                        |  |                 |  |          |               |                  |                      |         |
|                   | <u>In Network</u><br>Copay \$20<br>Hospital Copay \$500 | <u>Out of Network</u><br>Deductible \$2,000/\$4,000<br>70% to \$5,000/\$10,000 OOP | No Referral     | \$10 Generic<br>Brand Name \$250 ded.<br>\$25 Copay, Max. \$2000 | Atlantis | 416.97        | 833.94           | 838.53               | 1283.43 |
| 2                 | <b>POS 20/2000 HRA Option #2</b>                        |  |                 |  |          |               |                  |                      |         |
|                   | <u>In Network</u><br>Copay \$20<br>Hospital Copay \$500 | <u>Out of Network</u><br>Deductible \$2,000/\$4,000<br>70% to \$5,000/\$10,000 OOP | No Referral     | \$250 Deductible<br>\$7/30/50                                    | Atlantis | 433.56        | 867.12           | 871.89               | 1334.50 |
| 3                 | <b>POS 20/2000 HRA Option #3</b>                        |  |                 |  |          |               |                  |                      |         |
|                   | <u>In Network</u><br>Copay \$20<br>Hospital Copay \$500 | <u>Out of Network</u><br>Deductible \$2,000/\$4,000<br>70% to \$5,000/\$10,000 OOP | No Referral     | \$100 Deductible<br>\$7/30/50                                    | Atlantis | 440.99        | 881.98           | 886.83               | 1357.37 |
| 4                 | <b>POS 20/2000 HRA Option #4</b>                        |  |                 |  |          |               |                  |                      |         |
|                   | <u>In Network</u><br>Copay \$20<br>Hospital Copay \$500 | <u>Out of Network</u><br>Deductible \$2,000/\$4,000<br>70% to \$5,000/\$10,000 OOP | No Referral     | \$7/30/50  | Atlantis | 447.91        | 895.82           | 900.75               | 1378.67 |

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  
NEW BUSINESS RATES**

DATED: 2/17/10

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

| RATE SHEET PLAN #  | <b>EMBLEM HEALTH</b>   |   |                                  |                                  | 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>HSA HIGH DEDUCTIBLE EPO PLANS</b>                         |  |   |                                  |                                  |                        |         |                         |                  |                      |         |         |
| 1  | <b>EPO 3000 100% INDEXED*</b>  |   |                                  |                                  |                        |         |                         |                  |                      |         |         |
|  | In Network<br>Deductible \$3,000/\$5,950<br>100%                           | No Referral   | Covered in full after deductible | National                         | 288.81                 | 794.24  | 288.81                  | 635.39           | 548.78               | 852.02  |         |
| 2  | <b>EPO 5800 100% INDEXED*</b>  |   |                                  |                                  |                        |         |                         |                  |                      |         |         |
|  | In Network<br>Deductible \$5,800/\$11,600<br>100%                          | No Referral   | Covered in full after deductible | National                         | 211.82                 | 582.49  | 211.82                  | 465.95           | 402.41               | 624.81  |         |
| 3  | <b>EPO 1500 100% INDEXED*</b>  |   |                                  |                                  |                        |         |                         |                  |                      |         |         |
|  | In Network<br>Deductible \$1500/\$3000<br>100%                             | No Referral   | Covered in full after deductible | National                         | 440.63                 | 1211.72 | 440.63                  | 969.37           | 837.19               | 1299.83 |         |
| <b>NON HSA HIGH DEDUCTIBLE EPO PLAN</b>                      |  |   |                                  |                                  |                        |         |                         |                  |                      |         |         |
| 4  | <b>EPO 10,000 100%</b>   |   |                                  |                                  |                        |         |                         |                  |                      |         |         |
|  | In Network<br>EPO \$10,000-Non HSA<br>Deductible \$10,000/\$20,000<br>100% | No Referral   | Covered in full after deductible | National                         | 146.35                 | 402.45  | 146.35                  | 321.97           | 278.06               | 431.72  |         |
| <b>HSA HIGH DEDUCTIBLE PPO PLANS WITH SHARED DEDUCTIBLES</b> |  |   |                                  |                                  |                        |         |                         |                  |                      |         |         |
| 5  | <b>PPO 2500/100%</b>   |   |                                  |                                  |                        |         |                         |                  |                      |         |         |
|  | In Network<br>Deductible \$2500/\$5000<br>100%                             | Out of Network<br>Deductible \$5000/\$10000<br>80% Coinsurance \$7000/\$14000 OOP | No Referral                      | Covered in full after deductible | National               | 422.49  | 1161.85                 | 422.49           | 929.51               | 802.75  | 1246.37 |
| 6  | <b>PPO 5000/100%</b>   |   |                                  |                                  |                        |         |                         |                  |                      |         |         |
|  | In Network<br>Deductible \$5000/\$10000<br>100%                            | Out of Network<br>Deductible \$10000/\$20000<br>80% to \$12000/\$24000 OOP        | No Referral                      | Covered in full after deductible | National               | 286.92  | 789.02                  | 286.92           | 631.23               | 545.14  | 846.41  |

Rates are subject to NYS Insurance Department Approval.

**NOTES:**

- 1) EH PPO & EPO requires 50% participation in EH products (class carve-outs allowed). The 50% participation requirement can include participation in HIP and Comprehealth.
- 2) 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.