RELEASE DATE: 3/10/10

2nd QUARTER 2010

CONSUMER DRIVEN
RENEWAL RATES

DATED: 2/12/10

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

RATE SHEET PLAN #	ATLANTIS					Monthly Four Tier Rates			
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
1	**POS 20/2000 HRA Option #1**								
	In Network **Copay $20** **Hospital Copay $500**	**Out of Network** **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	416.97	833.94	838.53	1283.43
2	**POS 20/2000 HRA Option #2**								
	In Network **Copay $20** **Hospital Copay $500**	**Out of Network** **Deductible $2,000/$4,000** **70% to $5,000/$10,000 OOP**	No Referral	**$250 Deductible** **$7/30/50**	Atlantis	433.56	867.12	871.89	1334.50
3	**POS 20/2000 HRA Option #3**								
	In Network **Copay $20** **Hospital Copay $500**	**Out of Network** **Deductible $2,000/$4,000** **70% to $5,000/$10,000 OOP**	No Referral	**$100 Deductible** **$7/30/50**	Atlantis	440.99	881.98	886.83	1357.37
4	**POS 20/2000 HRA Option #4**								
	In Network **Copay $20** **Hospital Copay $500**	**Out of Network** **Deductible $2,000/$4,000** **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.

LIA Health Alliance
New York's Health Insurance Exchange

2nd QUARTER 2010

CONSUMER DRIVEN
RENEWAL RATES

DATED: 2/18/10

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

RATE SHEET PLAN #	EMBLEM HEALTH COPAY		Referral No Ref	RX	NET WORK	MONTHLY TWO TIER RATES EMPLOYEE ONLY	FAMILY	MONTHLY FOUR TIER RATES 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	402.50	1106.86	402.50	885.53	764.74	1187.39
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	270.98	745.20	270.98	596.15	514.84	799.37
3	**EPO 3000 100% INDEXED***										
	In Network Deductible $3,000/$5,950 100%		No Referral	Covered in full after deductible	National	288.81	794.24	288.81	635.39	548.78	852.02
4	**EPO 5800 100% INDEXED***										
	In Network Deductible $5,800/$11,600 100%		No Referral	Covered in full after deductible	National	211.82	582.49	211.82	465.95	402.41	624.81
5	**EPO 1500 100% INDEXED***										
	In Network Deductible $1500/$3000 100%		No Referral	Covered in full after deductible	National	440.63	1211.72	440.63	969.37	837.19	1299.83
	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	146.35	402.45	146.35	321.97	278.06	431.72
	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	514.94	1416.10	514.94	1132.91	978.41	1519.10
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	422.49	1161.85	422.49	929.51	802.75	1246.37
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	377.62	1038.47	377.62	830.78	717.51	1113.98
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	286.92	789.02	286.92	631.23	545.14	846.41

Rates are subject to NYS Insurance Department Approval.

NOTES:
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.**