

**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 #	<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 1200 90% INDEXED*</b>										
	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	<b>EPO 2500 70%</b>										
	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	<b>EPO 3000 100% INDEXED*</b>										
	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	<b>EPO 5800 100% INDEXED*</b>										
	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	<b>EPO 1500 100% INDEXED*</b>										
	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	
<b>NON HSA HIGH DEDUCTIBLE EPO PLAN</b>											
6	<b>EPO 10,000 100%</b>										
	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	
<b>HSA HIGH DEDUCTIBLE PPO PLANS WITH SHARED DEDUCTIBLES</b>											
7	<b>PPO 1200 80% INDEXED*</b>										
	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	<b>PPO 2500 100%</b>										
	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	<b>PPO 2500 80%</b>										
	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	<b>PPO 5000 100%</b>										
	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.