RELEASE DATE: 5/19/10

3rd QUARTER 2010

CONSUMER DRIVEN RENEWAL RATES

DATED: 5/19/10

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

SHEET PLAN #	ATLANTIS					MONTHLY 4 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	429.38	858.76	863.48	1321.63
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	446.38	892.76	897.67	1373.96
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	454.00	908.00	912.99	1397.41
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	461.09	922.18	927.25	1419.24

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.

Atlantis POS Rates are available for Renewals Only.

LIA Health Alliance
New York's Health Insurance Exchange

CONSUMER DRIVEN
RENEWAL RATES

DATED: 5/11/10

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

EMBLEM HEALTH

RATE SHEET PLAN #	COPAY		Referral No Ref	RX	NET WORK	MONTHLY TWO TIER RATES EMPLOYEE ONLY	MONTHLY TWO TIER RATES 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	427.61	1240.05	427.61	1026.24	791.07	1282.81
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	308.64	895.08	308.64	740.76	571.00	925.95
3	**EPO 3000 100% INDEXED***										
	In Network Deductible $3,000/$5,950 100%		No Referral	Covered in full after deductible	National	321.11	931.23	321.11	770.66	594.06	963.34
4	**EPO 5800 100% INDEXED***										
	In Network Deductible $5,800/$11,600 100%		No Referral	Covered in full after deductible	National	235.51	682.98	235.51	565.23	435.70	706.53
5	**EPO 1500 100% INDEXED***										
	In Network Deductible $1500/$3000 100%		No Referral	Covered in full after deductible	National	468.11	1357.53	468.11	1123.47	866.01	1404.34
	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	162.72	471.89	162.72	390.52	301.03	488.16
	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	547.05	1586.47	547.05	1312.94	1012.05	1641.16
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	481.22	1395.55	481.22	1154.93	890.27	1443.67
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	430.12	1247.34	430.12	1032.27	795.71	1290.34
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	319.01	925.13	319.01	765.63	590.17	957.04

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.**