

RELEASE DATE: 11/23/09



**TRADITIONAL
NEW BUSINESS RATES**

1st QUARTER 2010

DATED: 12/29/09 (11/9/09)

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

RATE SHEET PLAN #	ATLANTIS									
	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
HMO PLANS										
1	HMO 25/40A \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	342.36	878.15	342.36	684.72	688.49	1053.78
2	HMO 20A \$20 Copay \$500 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	357.97	918.19	357.97	715.94	719.88	1101.83
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0/30/50	Atlantis	373.30	957.51	373.30	746.60	750.71	1149.02
4	HMO 20 \$20 Copay \$500 Hospital Copay	No Referral	\$20/30/40	Atlantis	382.16	980.24	382.16	764.32	768.52	1176.29
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay	No Referral	\$0/30/50	Atlantis	425.34	1091.00	425.34	850.68	855.36	1309.20
6	HMO 20 Plus \$20 Copay No Hospital Copay	No Referral	\$20/30/40	Atlantis	437.44	1122.03	437.44	874.88	879.69	1346.44
POS PLANS										
7	POS 25/40 2000A In Network \$25 PCP/\$40 Spec Copay \$500 Hospital Copay Out of Network \$2000/4000 Deductible 70% to \$5,000/\$10,000 Max OOP	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	391.90	1005.22	391.90	783.80	788.11	1206.27
8	POS 20/2000 In Network \$20 Copay \$500 Hospital Copay Out of Network \$2000/4000 Deductible 70% to \$5,000/\$10,000 Max OOP	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	405.43	1039.93	405.43	810.86	815.32	1247.91
9	POS 25/40 2000 In Network \$25 PCP/\$40 Spec Copay \$500 Hospital Copay Out of Network \$2000/4000 Deductible 70% to \$5,000/\$10,000 Max OOP	No Referral	\$20/30/40	Atlantis	416.09	1067.27	416.09	832.18	836.76	1280.73
10	POS 20/1000 In Network \$20 Copay \$0 Hospital Copay Out of Network \$1000/2500 Deductible 70% to \$3,000/\$7,500 Max OOP	No Referral	\$0/30/50	Atlantis	513.55	1317.26	513.55	1027.10	1032.75	1580.71
11	POS 25/40 1000 Plus In Network \$25 PCP/\$40 Spec Copay \$0 Hospital Copay Out of Network \$1000/2500 Deductible 70% to \$3,000/\$7,500 Max OOP	No Referral	\$0/\$30/\$50	Atlantis	488.66	1253.41	488.66	977.32	982.70	1504.10
12	POS 20/500 In Network \$20 Copay \$0 Hospital Copay Out of Network \$500/1250 Deductible 70% to \$3,000/\$7,500 Max OOP	No Referral	\$20/30/40	Atlantis	563.16	1444.51	563.16	1126.32	1132.51	1733.41



TRADITIONAL
NEW BUSINESS RATES

1st QUARTER 2010

DATED: 11/9/09

RATE SHEET PLAN #	ATLANTIS Signature									
	COPAY	Referral No Ref	RX	Net Work	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
Signature HMO PLANS										
13	HMO 30/50/1000* \$30 PCP / \$50 Specialist Copay \$1000 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	271.73	696.99	271.73	543.46	546.45	836.38
14	HMO 30/50/750* \$30 PCP / \$50 Specialist Copay \$750 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	275.23	705.96	275.23	550.46	553.49	825.69
15	HMO 25/40/1000* \$25 PCP / \$40 Specialist Copay \$1000 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	276.73	709.81	276.73	553.46	556.50	851.77
16	HMO 0/50/1000* \$0 PCP / \$50 Specialist Copay \$1000 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	281.73	722.64	281.73	563.46	566.56	867.16
17	HMO 0/30/500* \$0 PCP / \$30 Specialist Copay \$500 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	325.73	835.50	325.73	651.46	655.04	1002.60
18	HMO 30/50/1000A* \$30 PCP / \$50 Specialist Copay \$1000 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	302.67	776.35	302.67	605.34	608.67	931.62
19	HMO 30/50/750A* \$30 PCP / \$50 Specialist Copay \$750 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	306.17	785.33	306.17	612.34	615.71	918.51
20	HMO 25/40/1000A* \$25 PCP / \$40 Specialist Copay \$1000 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	307.67	789.17	307.67	615.34	618.72	947.01
21	HMO 0/50/1000A* \$0 PCP / \$50 Specialist Copay \$1000 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	312.67	802.00	312.67	625.34	628.78	962.40
22	HMO 0/30/500A* \$0 PCP / \$30 Specialist Copay \$500 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	356.67	914.86	356.67	713.34	717.26	1097.83

*Plans and rates above have not met final approval of the NY Department of Insurance. Benefits and Rates are subject to change without notice

DATED: 1/4/10 (11/23/09)

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

RATE SHEET PLAN #	EMBLEM HEALTH		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		No Referral	None	National	294.97	756.26	294.97	648.85	563.87	874.74
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
2	CS EPO 40/2000		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
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
3	CS EPO 40/1000		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
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
4	CS EPO 30/1000		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
	\$30 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
5	CS EPO 30/500		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	1237.53
	\$30 Copay \$0 Copay Children	\$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
6	CS PPO 40/2000		No Referral	\$0/25/50 Annual Retail Max \$750 Mail Order Unlimited	National	516.08	1320.14	516.08	1135.53	983.98	1,527.09
	<u>In Network</u> \$40 Copay - Annual Ded for hospital based services \$1000/3000 80% to \$3000/9000 OOP \$0 Copay Children	<u>Out of Network</u> \$2000/6000 Annual Deductible 60% to \$6,000/18,000 OOP									
7	CS PPO 40/2000A		No Referral	\$0/25/50 Annual Retail Max \$3,000 Mail Order Unlimited	National	545.19	1394.37	545.19	1199.36	1039.29	1612.94
	<u>In Network</u> \$40 Copay - Annual Ded for hospital based services \$1000/3000 80% to \$3000/9000 OOP \$0 Copay Children	<u>Out of Network</u> \$2000/6000 Annual Deductible 60% to \$6,000/18,000 OOP									
NON COST SHARING											
8	EPO 40/1000		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
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
9	EPO 30/1000A		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
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay									
10	EPO 30/1000		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
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay									
11	EPO 30/500		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
	\$30 Copay \$0 Copay Children	\$500 Hospital Copay									

TRADITIONAL
NEW BUSINESS RATES (continued)

1st QUARTER 2010

RATE SHEET PLAN #	COPAY		Referral No Ref	RX	NET WORK	Monthly Two Tier Rates			Monthly Four Tier Rates			
						EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
	EMBLEM HEALTH											
	NON COST SHARING (continued)											
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	616.96	1577.25	616.96	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 \$50 Annual Retail Max \$1000 Mail Order Unlimited	National	638.87	1633.23	638.87	1405.45	1217.27	1889.26
16	PPO 30/1000A	<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 \$50 Annual Retail Max \$3000 Mail Order Unlimited	National	662.07	1692.41	662.07	1456.49	1261.36	1957.71
	HMO- COMPREHEALTH											
17	HMO-30/50/1000	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	273.30	699.67	273.30	601.26	522.00	808.97
18	HMO-30/50/500	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	291.99	747.81	291.99	642.38	557.7	864.29
19	HMO-25/40/500A	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$25 Generic/\$35 Brand	Comprehealth	329.96	845.00	329.96	725.93	630.24	976.69
20	HMO-25/40/500	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$0 Generic \$30 Brand	Comprehealth	396.29	1014.80	396.29	871.89	756.97	1173.07
21	HMO-20/25/200	\$20 PCP / \$25 Specialist Copay \$0 Copay Children	\$200 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	347.70	890.13	347.70	764.93	664.11	1029.20

Rates are subject to NYS Insurance Department approval.

NOTES:

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

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

NY Metro is a limited network.

TRADITIONAL
NEW BUSINESS RATES

DATED: 11/23/09

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RATE SHEET PLAN #	HIP	COPAY	Referral No Ref	RX	NET WORK	Monthly Two Tier Rates		Monthly Three Tier Rates			Monthly Four Tier Rates			
						EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE + ONE	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
COST SHARING														
1	EPO 25 SMART START (Limited Hospital Based Network) \$25 Copay Hospital Copay \$250 1st two days, then \$100 per day, Max \$1400 per stay; Annual Benefit Max \$100,000 per individual Lifetime Max \$500,000 per individual		No Referral	NONE	Smart Start			349.83	734.64	944.54				
2	EPO 30/50 1000A Select \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.		No Referral	\$15 (Generic Only)	SELECT PRIME	312.74	807.13	312.74	602.86	958.67	312.74	625.57	581.78	957.15
3	EPO 30/50 1000 Select \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.		No Referral	\$20/30/50	SELECT PRIME	364.31	933.49	364.31	697.04	1108.61	364.31	728.72	677.71	1114.92
4	EPO 25/1000 Select \$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.		No Referral	\$20/30/50	SELECT PRIME	390.19	997.04	390.19	744.49	1184.07	390.19	780.37	725.73	1193.93
5	PPO 15/1000 Select In Network \$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max. Out of Network \$1000/2000 Deductible 80% to \$3000/6000 coin max.		No Referral	\$15/30/50	SELECT PRIME	576.21	1473.16	576.21	1100.12	1749.56	576.21	1152.42	1071.72	1763.14
POS PLANS														
6	POS 20/1000 In Network \$20 Copay \$250 Hospital Copay Out of Network \$1000/2000 Deductible 70% to \$2000/\$4000 OOP		Referral	\$7/30/50	PRIME	716.87	1,858.50	716.87	1387.88	2207.21	716.87	1433.73	1333.36	2193.50

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