

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										
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	None	National	294.97	756.26	294.97	648.85	563.87	874.74
2	CS EPO 40/2000										
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP	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
3	CS EPO 40/1000										
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	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
4	CS EPO 30/1000										
	\$30 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	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
5	CS EPO 30/500										
	\$30 Copay \$0 Copay Children	\$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	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
6	CS PPO 40/2000										
	<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	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
7	CS PPO 40/2000A										
	<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	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
NON COST SHARING											
8	EPO 40/1000										
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay	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
9	EPO 30/1000A										
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay	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
10	EPO 30/1000										
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay	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
11	EPO 30/500										
	\$30 Copay \$0 Copay Children	\$500 Hospital Copay	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

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.