

**TRADITIONAL
RENEWAL RATES**

1st QUARTER 2010

DATED: 1/4/10 (11/19/09)

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

RATE SHEET	EMBLEM HEALTH										
	Monthly Two Tier Rates					Monthly Four Tier Rates					
PLAN #	COPAY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
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	944.8	
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	362.5	928.47	362.5	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	1281.2	
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
RENEWAL RATES (continued)

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RATE SHEET	EMBLEM HEALTH														
	COPAY			Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	Monthly Two Tier Rates			Monthly Four Tier Rates			
PLAN #								EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY				
NON COST SHARING (continued)															
12	EPO 20A														
	\$20 Copay	\$0 Hospital Copay	No	\$0 Generic	National	616.96	1577.25	616.96	1357.2	1175.6	1824.55				
	\$0 Copay Children		Referral	\$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited											
13	EPO 20														
	\$20 Copay	\$0 Hospital Copay	No	\$0/30/50	National	644.20	1646.72	644.2	1417.14	1227.35	1904.91				
	\$0 Copay Children		Referral												
14	PPO 25/1000														
	<u>In Network</u>	<u>Out of Network</u>	No	\$0/25/40	National	905.57	2313.28	905.57	1992.09	1723.98	2675.96				
	\$25 Copay	\$1000/3000 Annual Deductible	Referral												
	\$0 Copay Children	70% to \$3000/9000 OOP													
	\$500 Hospital Copay														
15	PPO 30/1000														
	<u>In Network</u>	<u>Out of Network</u>	No	\$0 Generic	National	638.87	1633.23	638.87	1405.45	1217.27	1889.26				
	\$30 Copay	\$1000/3000 Annual Deductible	Referral	\$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited											
	\$0 Copay Children	70% to \$3000/9000 OOP													
	\$500 Hospital Copay														
16	PPO 30/1000A														
	<u>In Network</u>	<u>Out of Network</u>	No	\$0 Generic	National	662.07	1692.41	662.07	1456.49	1261.36	1957.71				
	\$30 Copay	\$1000/3000 Annual Deductible	Referral	\$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$3000 Mail Order Unlimited											
	\$0 Copay Children	70% to \$3000/9000 OOP													
	\$500 Hospital Copay														
HMO- COMPREHEALTH															
17	HMO-30/50/1000														
	\$30 PCP / \$50 Specialist Copay	\$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	273.30	699.67	273.30	601.26	522.00	808.97				
	\$0 Copay Children														
18	HMO-30/50/500														
	\$30 PCP / \$50 Specialist Copay	\$500 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	291.99	747.81	291.99	642.38	557.70	864.29				
	\$0 Copay Children														
19	HMO-25/40/500A														
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay	Referral	\$25 Generic/\$35 Brand	Comprehealth	329.96	845.00	329.96	725.93	630.24	976.69				
	\$0 Copay Children														
20	HMO-25/40/500														
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay	Referral	\$0 Generic \$30 Brand	Comprehealth	396.29	1014.80	396.29	871.89	756.97	1173.07				
	\$0 Copay Children														
21	HMO-20/25/200														
	\$20 PCP / \$25 Specialist Copay	\$200 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	347.70	890.13	347.70	764.93	664.11	1029.20				
	\$0 Copay Children														

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.