RELEASE DATE: 3/10/10

# TRADITIONAL NEW BUSINESS RATES

## 2nd QUARTER 2010

**DATED: 2/12/10**

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

## ATLANTIS

| 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 | Monthly Four Tier Rates: EMPLOYEE +SPOUSE | Monthly Four Tier Rates: EMPLOYEE +CHILD(ren) | Monthly Four Tier Rates: FAMILY |
|---|---|---|---|---|---|---|---|---|---|---|
| | **HMO PLANS** | | | | | | | | | |
| 1 | **HMO 25/40A**<br>**$25 PCP / $40 Specialist Copay**<br>**$500 Hospital Copay** | No Referral | **$0 Generic**<br>**Brand Name $250 Ded**<br>**$25 Copay, Max $2000** | Atlantis | 350.92 | 900.11 | 350.92 | 701.84 | 705.70 | 1080.13 |
| 2 | **HMO 20A**<br>**$20 Copay**<br>**$500 Hospital Copay** | No Referral | **$0 Generic**<br>**Brand Name $250 Ded**<br>**$25 Copay, Max $2000** | Atlantis | 366.92 | 941.15 | 366.92 | 733.84 | 737.88 | 1129.38 |
| 3 | **HMO 25/40**<br>**$25 PCP / $40 Specialist Copay**<br>**$500 Hospital Copay** | No Referral | **$0/30/50** | Atlantis | 382.63 | 981.45 | 382.63 | 765.26 | 769.47 | 1177.74 |
| 4 | **HMO 20**<br>**$20 Copay**<br>**$500 Hospital Copay** | No Referral | **$20/30/40** | Atlantis | 391.72 | 1004.76 | 391.72 | 783.44 | 787.75 | 1205.71 |
| 5 | **HMO 25/40 Plus**<br>**$25 PCP / $40 Specialist Copay**<br>**No Hospital Copay** | No Referral | **$0/30/50** | Atlantis | 435.97 | 1118.26 | 435.97 | 871.94 | 876.74 | 1341.92 |
| 6 | **HMO 20 Plus**<br>**$20 Copay**<br>**No Hosptial Copay** | No Referral | **$20/30/40** | Atlantis | 448.38 | 1150.09 | 448.38 | 896.76 | 901.69 | 1380.11 |
| | **POS PLANS** | | | | | | | | | |
| 7 | **POS 25/40 2000A**<br>**In Network**: **$25 PCP/$40 Spec Copay**, **$500 Hospital Copay**<br>**Out of Network**: **$2000/4000 Deductible**, 70% to $5,000/$10,000 Max OOP | No Referral | **$0 Generic**<br>**Brand Name $250 Ded**<br>**$25 Copay, Max $2000** | Atlantis | 403.56 | 1035.13 | 403.56 | 807.12 | 811.56 | 1242.16 |
| 8 | **POS 20/2000**<br>**In Network**: **$20 Copay**, **$500 Hospital Copay**<br>**Out of Network**: **$2000/4000 Deductible**, 70% to $5,000/$10,000 Max OOP | No Referral | **$0 Generic**<br>**Brand Name $250 Ded**<br>**$25 Copay, Max $2000** | Atlantis | 417.49 | 1070.86 | 417.49 | 834.98 | 839.57 | 1285.03 |
| 9 | **POS 25/40 2000**<br>**In Network**: **$25 PCP/$40 Spec Copay**, **$500 Hospital Copay**<br>**Out of Network**: **$2000/4000 Deductible**, 70% to $5,000/$10,000 Max OOP | No Referral | **$20/30/40** | Atlantis | 428.36 | 1098.74 | 428.36 | 856.72 | 861.43 | 1318.49 |
| 10 | **POS 20/1000**<br>**In Network**: **$20 Copay**, **$0 Hospital Copay**<br>**Out of Network**: **$1000/2500 Deductible**, 70% to $3,000/$7,500 Max OOP | No Referral | **$0/30/50** | Atlantis | 528.70 | 1356.12 | 528.70 | 1057.40 | 1063.22 | 1627.34 |
| 11 | **POS 25/40 1000 Plus**<br>**In Network**: **$25 PCP/$40 Spec Copay**, **$0 Hospital Copay**<br>**Out of Network**: **$1000/2500 Deductible**, 70% to $3,000/$7,500 Max OOP | No Referral | **$0/$30/$50** | Atlantis | 503.06 | 1290.35 | 503.06 | 1006.12 | 1011.65 | 1548.42 |
| 12 | **POS 20/500**<br>**In Network**: **$20 Copay**, **$0 Hospital Copay**<br>**Out of Network**: **$500/1250 Deductible**, 70% to $3,000/$7,500 Max OOP | No Referral | **$20/30/40** | Atlantis | 579.84 | 1487.29 | 579.84 | 1159.68 | 1166.06 | 1784.75 |

# TRADITIONAL

# NEW BUSINESS RATES

## 2nd QUARTER 2010

LIA Health Alliance
New York's Health Insurance Exchange

REVISED: 3/10/10 (2/17/10)

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## EMBLEM HEALTH

| RATE SHEET PLAN # | COPAY | | Referral No Ref | RX | NET WORK | Monthly Two Tier Rates | | Monthly Four Tier Rates | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **COST SHARING** | | | | | | | | | | | |
| 1 | **CS EPO 40/1000A**<br>$40 Copay<br>$0 Copay Children | $1000/3000 Annual Deductible<br>for hospital based services<br>with 90% to $500/1,500 OOP | No Referral | None | National | 318.53 | 880.03 | 318.53 | 700.68 | 608.74 | 944.38 |
| 2 | **CS EPO 40/2000**<br>$40 Copay<br>$0 Copay Children | $2000/6000 Annual Deductible<br>for hospital based services<br>with 80% to $3,000/9,000 OOP | No Referral | $0 Generic<br>$50 Ded, Brand $30, Non Pref $50<br>Annual Retail Max $1,000<br>Mail Order Unlimited | National | 340.76 | 941.16 | 340.76 | 749.69 | 651.02 | 1010.08 |
| 3 | **CS EPO 40/1000**<br>$40 Copay<br>$0 Copay Children | $1000/3000 Annual Deductible<br>for hospital based services<br>with 90% to $500/1,500 OOP | No Referral | $0 Generic<br>$50 Ded, Brand $30, Non Pref $50<br>Annual Retail Max $1,000<br>Mail Order Unlimited | National | 388.09 | 1071.31 | 388.09 | 853.72 | 740.90 | 1149.60 |
| 4 | **CS EPO 30/1000**<br>$30 Copay<br>$0 Copay Children | $1000/3000 Annual Deductible<br>for hospital based services<br>with 90% to $500/1,500 OOP | No Referral | $0 Generic<br>$50 Ded, Brand $30, Non Pref $50<br>Annual Retail Max $1,000<br>Mail Order Unlimited | National | 404.40 | 1116.19 | 404.40 | 889.63 | 771.92 | 1197.77 |
| 5 | **CS EPO 30/500**<br>$30 Copay<br>$0 Copay Children | $500/1500 Annual Deductible<br>for hospital based services<br>with 90% to $500/1,500 OOP | No Referral | $0 Generic<br>$50 Ded, Brand $30, Non Pref $50<br>Annual Retail Max $3,000<br>Mail Order Unlimited | National | 446.94 | 1233.20 | 446.94 | 983.18 | 852.70 | 1323.20 |
| 6 | **CS PPO 40/2000**<br>In Network<br>$40 Copay - Annual Ded<br>for hospital based services<br>$1000/3000 80% to<br>$3000/9000 OOP<br>$0 Copay Children | Out of Network<br>$2000/6000 Annual Deductible<br>60% to $6,000/18,000 OOP | No Referral | $0 Generic<br>$50 Ded, Brand $25, Non Pref $50<br>Annual Retail Max $750<br>Mail Order Unlimited | National | 555.66 | 1532.17 | 555.66 | 1222.42 | 1059.30 | 1,644.02 |
| 7 | **CS PPO 40/2000A**<br>In Network<br>$40 Copay - Annual Ded<br>for hospital based services<br>$1000/3000 80% to<br>$3000/9000 OOP<br>$0 Copay Children | Out of Network<br>$2000/6000 Annual Deductible<br>60% to $6,000/18,000 OOP | No Referral | $0 Generic<br>$50 Ded, Brand $25, Non Pref $50<br>Annual Retail Max $3,000<br>Mail Order Unlimited | National | 586.40 | 1616.71 | 586.40 | 1290.04 | 1117.71 | 1,734.67 |
| **NON COST SHARING** | | | | | | | | | | | |
| 8 | **EPO 40/1000**<br>$40 Copay<br>$0 Copay Children | $1000 Hospital Copay | No Referral | $0 Generic<br>$50 Ded, Brand $30, Non Pref $50<br>Annual Retail Max $1000<br>Mail Order Unlimited | National | 415.69 | 1147.23 | 415.69 | 914.46 | 793.35 | 1231.08 |
| 9 | **EPO 30/1000A**<br>$30 Copay<br>$0 Copay Children | $1000 Hospital Copay | No Referral | $0 Generic<br>$50 Ded, Brand $30, Non Pref $50<br>Annual Retail Max $1,000<br>Mail Order Unlimited | National | 449.35 | 1239.78 | 449.35 | 988.47 | 857.30 | 1330.33 |
| 10 | **EPO 30/1000**<br>$30 Copay<br>$0 Copay Children | $1000 Hospital Copay | No Referral | $0 Generic<br>$50 Ded, Brand $30, Non Pref $50<br>Annual Retail Max $3,000<br>Mail Order Unlimited | National | 470.56 | 1293.13 | 470.56 | 1035.12 | 897.60 | 1392.87 |
| 11 | **EPO 30/500**<br>$30 Copay<br>$0 Copay Children | $500 Hospital Copay | No Referral | $0 Generic<br>$50 Ded, Brand $30, Non Pref $50<br>Annual Retail Max $3,000<br>Mail Order Unlimited | National | 511.92 | 1411.91 | 511.92 | 1126.15 | 976.17 | 1514.90 |

Health Alliance
New York's Health Insurance Exchange



| 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) | FAMILY |
| | **NON COST SHARING (continued)** | | | | | | | | | |
| 12 | **PPO 25/1000 *** In Network: $25 Copay, $0 Copay Children, $500 Hospital Copay; Out of Network: $1000/3000 Annual Deductible, 70% to $3000/9000 OOP | No Referral | $0/25/40 | National | | | 993.38 | 2185.28 | 1890.94 | 2935.16 |
| 13 | **PPO 30/1000 *** In Network: $30 Copay, $0 Copay Children, $500 Hospital Copay; Out of Network: $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 | | | 698.69 | 1537.06 | 1331.05 | 2065.89 |
| 14 | **PPO 30/1000A *** In Network: $30 Copay, $0 Copay Children, $500 Hospital Copay; Out of Network: $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 | | | 723.19 | 1590.96 | 1377.61 | 2138.17 |
| | **HMO- COMPREHEALTH** | | | | | | | | | |
| 15 | **HMO-30/50/1000** $30 PCP / $50 Specialist Copay, $1000 Hospital Copay, $0 Copay Children | Referral | $15 Generic Only | Comprehealth | 273.44 | 700.01 | 273.44 | 601.56 | 522.25 | 809.36 |
| 16 | **HMO-30/50/500** $30 PCP / $50 Specialist Copay, $500 Hospital Copay, $0 Copay Children | Referral | $15 Generic Only | Comprehealth | 292.13 | 747.85 | 292.13 | 642.68 | 557.95 | 864.68 |
| 17 | **HMO-25/40/500A** $25 PCP / $40 Specialist Copay, $500 Hospital Copay, $0 Copay Children | Referral | $25 Generic/$35 Brand | Comprehealth | 330.46 | 845.97 | 330.46 | 727.02 | 631.18 | 978.16 |
| 18 | **HMO-25/40/500** $25 PCP / $40 Specialist Copay, $500 Hospital Copay, $0 Copay Children | Referral | $0 Generic, $30 Brand | Comprehealth | 398.46 | 1020.05 | 398.46 | 876.62 | 761.06 | 1179.44 |
| 19 | **HMO-20/25/200** $20 PCP / $25 Specialist Copay, $200 Hospital Copay, $0 Copay Children | Referral | $15 Generic Only | Comprehealth | 347.84 | 890.47 | 347.84 | 765.23 | 664.36 | 1029.59 |

Rates are subject to NYS Insurance Department approval.

**NOTES**:

1) EH PPO & EPO requires 50% participation in EH products (class carve-outs allowed). The 50% participation requirement can include participation in HIP and Comprehealth.

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

3) NY Metro is a limited network.

**4) * Non Cost Share PPO Plans #12 PPO 25/1000, #13 PPO 30/1000 and #14 PPO 30/1000A are only available with 4-Tier rates. If an employee chooses one of these plans, then 4-Tier rates must be chosen for all other employees who choose an Emblem CS PPO, EPO, HSA or Comprehealth plan.**

LIA Health Alliance
New York's Health Insurance Exchange

**2nd QUARTER 2010**

## TRADITIONAL

## NEW BUSINESS RATES

**DATED: 2/23/10**

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

| RATE SHEET PLAN # | HIP<br>COPAY | Referral No Ref | RX | NET WORK | Monthly Two Tier Rates<br>EMPLOYEE ONLY | FAMILY | Monthly Three Tier Rates<br>EMPLOYEE ONLY | EMPLOYEE + ONE | FAMILY | Monthly Four Tier Rates<br>EMPLOYEE ONLY | EMPLOYEE +SPOUSE | EMPLOYEE +CHILD(ren) | FAMILY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **COST SHARING** | | | | | | | | | | | | |
| 1 | **EPO 25 SMART START (Limited Hospital Based Network)**<br>$25 Copay<br>Hospital Copay $250 1st two days,<br>then $100 per day, Max $1400 per stay;<br>Annual Benefit Max $100,000 per individual<br>Lifetime Max $500,000 per individual | No Referral | **NONE** | Smart Start | | | 356.83 | 749.34 | 963.44 | | | | |
| 2 | **EPO 30/50 1000A Select**<br>$30 PCP / $50 Specialist Copay, $1000 ded. hospital based services.<br>90% coin, $1000 coin max. | No Referral | **$15 (Generic Only)** | SELECT PRIME | 320.27 | 826.43 | 320.27 | 617.27 | 981.58 | 320.27 | 640.66 | 595.80 | 980.21 |
| 3 | **EPO 30/50 1000 Select**<br>$30 PCP / $50 Specialist Copay, $1000 ded. hospital based services.<br>90% coin, $1000 coin max. | No Referral | **$20/30/50** | SELECT PRIME | 373.14 | 955.96 | 373.14 | 713.80 | 1135.27 | 373.14 | 746.39 | 694.13 | 1141.93 |
| 4 | **EPO 25/1000 Select**<br>$25 Copay, $1000 ded. hospital based services.<br>90% coin, $500 coin max. | No Referral | **$20/30/50** | SELECT PRIME | 399.07 | 1019.63 | 399.07 | 761.34 | 1210.87 | 399.07 | 798.13 | 742.24 | 1221.09 |
| 5 | **PPO 15/1000 Select**<br>**In Network**: $15 Copay, $1000 ded. hospital based services 90% coin, $500 coin max.<br>**Out of Network**: $1000/2000 Deductible 80% to $3000/6000 coin max. | No Referral | **$15/30/50** | SELECT PRIIME | 588.39 | 1504.25 | 588.39 | 1123.31 | 1786.45 | 588.39 | 1176.78 | 1094.37 | 1800.41 |
| | **POS PLANS** | | | | | | | | | | | | |
| 6 | **POS 20/1000**<br>**In Network**: $20 Copay $250 Hospital Copay<br>**Out of Network**: $1000/2000 Deductible 70% to $2000/$4000 OOP | Referral | **$7/30/50** | PRIME | 735.48 | 1,906.16 | 735.48 | 1423.46 | 2263.80 | 735.48 | 1470.95 | 1368.00 | 2250.47 |

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