RELEASE DATE: 5/17/10

TRADITIONAL NEW BUSINESS RATES

3rd QUARTER 2010

DATED: 5/14/10

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** **$25 PCP / $40 Specialist Copay** **$500 Hospital Copay**	No Referral	**$0 Generic** **Brand Name $250 Ded** **$25 Copay, Max $2000**	Atlantis	359.69	922.60	359.69	719.38	723.34	1107.13
2	**HMO 20A** **$20 Copay** **$500 Hospital Copay**	No Referral	**$0 Generic** **Brand Name $250 Ded** **$25 Copay, Max $2000**	Atlantis	376.09	964.67	376.09	752.18	756.32	1157.61
3	**HMO 25/40** **$25 PCP / $40 Specialist Copay** **$500 Hospital Copay**	No Referral	**$0/30/50**	Atlantis	392.19	1005.97	392.19	784.38	788.69	1207.16
4	**HMO 20** **$20 Copay** **$500 Hospital Copay**	No Referral	**$20/30/40**	Atlantis	401.51	1029.87	401.51	803.02	807.44	1235.85
5	**HMO 25/40 Plus** **$25 PCP / $40 Specialist Copay** **No Hospital Copay**	No Referral	**$0/30/50**	Atlantis	446.87	1146.22	446.87	893.74	898.66	1375.47
6	**HMO 20 Plus** **$20 Copay** **No Hosptial Copay**	No Referral	**$20/30/40**	Atlantis	459.59	1178.85	459.59	919.18	924.24	1414.62

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LIA Health Alliance
New York's Health Insurance Exchange

TRADITIONAL NEW BUSINESS RATES

REVISED: 5/17/10

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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** $40 Copay $0 Copay Children	$1000/3000 Annual Deductible for hospital based services with 90% to $500/1,500 OOP	No Referral	None	National	325.13	947.09	325.13	780.34	605.29	980.39
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	348.09	1013.66	348.09	835.43	647.77	1049.28
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	396.40	1153.76	396.40	951.38	737.14	1194.19
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	413.05	1202.03	413.05	991.33	767.93	1244.14
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	456.55	1328.18	456.55	1095.73	848.40	1374.65
6	**CS PPO 40/2000** In Network $40 Copay - Annual Ded for hospital based services $1000/3000 80% to $3000/9000 OOP $0 Copay Children	Out of Network $2000/6000 Annual Deductible 60% to $6,000/18,000 OOP	No Referral	$0 Generic $50 Ded, Brand $25, Non Pref $50 Annual Retail Max $750 Mail Order Unlimited	National	574.45	1670.13	574.45	1378.71	1066.54	1728.36
7	**CS PPO 40/2000A** In Network $40 Copay - Annual Ded for hospital based services $1000/3000 80% to $3000/9000 OOP $0 Copay Children	Out of Network $2000/6000 Annual Deductible 60% to $6,000/18,000 OOP	No Referral	$0 Generic $50 Ded, Brand $25, Non Pref $50 Annual Retail Max $3,000 Mail Order Unlimited	National	605.95	1761.45	605.95	1454.29	1124.81	1822.84
	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	426.24	1240.31	426.24	1022.98	792.35	1283.72
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	460.76	1340.40	460.76	1105.83	856.20	1387.28
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	482.49	1403.42	482.49	1157.99	896.39	1452.48
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	524.91	1526.43	524.91	1259.79	974.85	1579.72

TRADITIONAL
NEW BUSINESS RATES (continued)

RATE SHEET PLAN #	EMBLEM HEALTH COPAY		Referral No Ref	RX	NET WORK	Monthly Two Tier Rates EMPLOYEE ONLY	FAMILY	Monthly Four Tier Rates 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			1036.00	2486.41	1920.38	3113.00
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			728.42	1748.19	1351.35	2190.22
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			753.52	1808.44	1397.79	2265.52
	HMO- COMPREHEALTH										
15	**HMO-30/50/1000** **$30 PCP / $50 Specialist Copay** **$0 Copay Children**	**$1000 Hospital Copay**	Referral	**$15 Generic Only**	Comprehealth	260.37	755.08	260.37	624.88	481.68	781.12
16	**HMO-30/50/500** **$30 PCP / $50 Specialist Copay** **$0 Copay Children**	**$500 Hospital Copay**	Referral	**$15 Generic Only**	Comprehealth	290.20	841.58	290.20	696.45	536.86	870.61
17	**HMO-25/40/500A** **$25 PCP / $40 Specialist Copay** **$0 Copay Children**	**$500 Hospital Copay**	Referral	**$25 Generic/$35 Brand**	Comprehealth	330.17	957.50	330.17	792.41	610.80	990.51
18	**HMO-25/40/500** **$25 PCP / $40 Specialist Copay** **$0 Copay Children**	**$500 Hospital Copay**	Referral	**$0 Generic** **$30 Brand**	Comprehealth	399.87	1159.61	399.87	959.67	739.54	1199.55
19	**HMO-20/25/200** **$20 PCP / $25 Specialist Copay** **$0 Copay Children**	**$200 Hospital Copay**	Referral	**$15 Generic Only**	Comprehealth	352.27	1021.55	352.27	845.45	659.69	1056.82

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℠

3rd QUARTER 2010

TRADITIONAL

NEW BUSINESS RATES

DATED: 5/11/10

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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
	HIP									
	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			366.69	880.06	678.38	1100.07
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	318.25	911.29	318.25	753.47	588.99	956.28
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	372.44	1068.46	372.44	883.54	689.26	1118.87
4	**EPO 25/1000 Select** $25 Copay, $1000 ded. hospital based services. 90% coin, $500 coin max.	No Referral	**$20/30/50**	SELECT PRIME	399.55	1147.10	399.55	948.62	739.42	1200.22
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 PRIIME	645.10	1859.18	645.10	1537.93	1193.69	1936.83
	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	710.96	1,982.53	710.96	1706.30	1340.24	2173.41

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