

REVISED RELEASE DATE: 11/19/10



**TRADITIONAL  
NEW BUSINESS RATES**

**4th QUARTER 2010  
OCTOBER & NOVEMBER**

DATED: 8/16/10

Please visit our web site, [www.LIAHealthAlliance.com](http://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  |
| <b>HMO PLANS</b>  |   |                 |   |          |               |                         |               |                  |                      |         |
| 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 | 375.91        | 964.21                  | 375.91        | 751.82           | 755.96               | 1157.05 |
| 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 | 393.05        | 1008.17                 | 393.05        | 786.10           | 790.42               | 1209.81 |
| 3                 | HMO 25/40<br>\$25 PCP / \$40 Specialist Copay<br>\$500 Hospital Copay   | No Referral     | \$0/30/50   | Atlantis | 409.88        | 1051.34                 | 409.88        | 819.76           | 824.27               | 1261.61 |
| 4                 | HMO 20<br>\$20 Copay<br>\$500 Hospital Copay                            | No Referral     | \$20/30/40  | Atlantis | 419.62        | 1076.33                 | 419.62        | 839.24           | 843.86               | 1291.59 |
| 5                 | HMO 25/40 Plus<br>\$25 PCP / \$40 Specialist Copay<br>No Hospital Copay | No Referral     | \$0/30/50   | Atlantis | 467.02        | 1197.91                 | 467.02        | 934.04           | 939.18               | 1437.49 |
| 6                 | HMO 20 Plus<br>\$20 Copay<br>No Hospital Copay                          | No Referral     | \$20/30/40  | Atlantis | 480.32        | 1232.02                 | 480.32        | 960.64           | 965.92               | 1478.42 |

Rates are subject to NYS Insurance Department approval.

REVISED: 11/22/10 (9/9/10)

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| RATE SHEET | EMBLEM HEALTH   |  |                 |  |          |               |         |               |                  |                    |         |
|------------|---|--|-----------------|--|----------|---------------|---------|---------------|------------------|--------------------|---------|
|            | COPAY   |  | Referral No Ref | RX   | NET WORK | EMPLOYEE ONLY | FAMILY  | EMPLOYEE ONLY | EMPLOYEE +SPOUSE | EMPLOYEE +CHILDREN | FAMILY  |
|            | <b>COST SHARING</b>   |  |                 |  |          |               |         |               |                  |                    |         |
| 1          | CS EPO 40/1000A<br>\$40 Copay<br>\$0 Copay Children   |  | No Referral     | None   | National | 341.17        | 993.79  | 341.17        | 818.86           | 635.13             | 1028.74 |
|            | \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP   |  |                 |  |          |               |         |               |                  |                    |         |
| 2          | CS EPO 40/2000<br>\$40 Copay<br>\$0 Copay Children  |  | No Referral     | \$0 Generic Brand \$30, Non Pref \$50            | National | 416.98        | 1213.16 | 416.98        | 1000.75          | 775.38             | 1256.16 |
|            | \$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP   |  |                 |  |          |               |         |               |                  |                    |         |
| 3          | CS EPO 40/2000A<br>\$40 Copay<br>\$0 Copay Children   |  | No Referral     | \$15 GENERIC ONLY                                | National | 303.35        | 882.17  | 303.35        | 725.52           | 565.84             | 914.67  |
|            | \$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP   |  |                 |  |          |               |         |               |                  |                    |         |
| 4          | CS EPO 40/1000<br>\$40 Copay<br>\$0 Copay Children  |  | No Referral     | \$0 Generic Brand \$30, Non Pref \$50            | National | 467.67        | 1360.62 | 467.67        | 1122.43          | 869.15             | 1408.22 |
|            | \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP   |  |                 |  |          |               |         |               |                  |                    |         |
| 5          | CS EPO 40/1000B<br>\$40 Copay<br>\$0 Copay Children   |  | No Referral     | \$15 GENERIC ONLY                                | National | 354.04        | 1029.19 | 354.04        | 847.20           | 659.61             | 1066.73 |
|            | \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP   |  |                 |  |          |               |         |               |                  |                    |         |
| 6          | CS EPO 30/500<br>\$30 Copay<br>\$0 Copay Children   |  | No Referral     | \$0 Generic Brand \$30, Non Pref \$50            | National | 508.00        | 1476.92 | 508.00        | 1219.17          | 943.73             | 1529.17 |
|            | \$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP  |  |                 |  |          |               |         |               |                  |                    |         |
| 7          | CS PPO 40/2000A<br><u>In Network</u><br>\$40 Copay - Annual Ded for hospital based services<br>\$1000/3000 80% to \$3000/9000 OOP<br>\$0 Copay Children |  | No Referral     | \$0 Generic \$100 Ded, Brand \$25, Non Pref \$50 | National | 660.60        | 1920.06 | 660.60        | 1585.42          | 1226.04            | 1986.97 |
|            | <u>Out of Network</u><br>\$2000/6000 Annual Deductible 60% to \$6,000/18,000 OOP  |  |                 |  |          |               |         |               |                  |                    |         |
|            | <b>NON COST SHARING</b>   |  |                 |  |          |               |         |               |                  |                    |         |
| 8          | EPO 40/1000<br>\$40 Copay<br>\$0 Copay Children   |  | No Referral     | \$0 Generic Brand \$30, Non Pref \$50            | National | 498.96        | 1451.38 | 498.96        | 1197.51          | 927.04             | 1502.11 |
|            | \$1000 Hospital Copay   |  |                 |  |          |               |         |               |                  |                    |         |
| 9          | EPO 40/1000A<br>\$40 Copay<br>\$0 Copay Children  |  | No Referral     | \$15 GENERIC ONLY                                | National | 385.33        | 1119.95 | 385.33        | 922.28           | 717.50             | 1160.62 |
|            | \$1000 Hospital Copay   |  |                 |  |          |               |         |               |                  |                    |         |
| 10         | EPO 30/500<br>\$30 Copay<br>\$0 Copay Children  |  | No Referral     | \$0 Generic Brand \$30, Non Pref \$50            | National | 579.70        | 1685.50 | 579.70        | 1391.27          | 1076.38            | 1744.31 |
|            | \$500 Hospital Copay  |  |                 |  |          |               |         |               |                  |                    |         |

TRADITIONAL  
NEW BUSINESS RATES (continued)

| RATE SHEET PLAN #        | EMBLEM HEALTH  |                       |                 |                           |               |                        |               |                         |                      |        |         |
|--------------------------|--|-----------------------|-----------------|---------------------------|---------------|------------------------|---------------|-------------------------|----------------------|--------|---------|
|                          | 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 |         |
| <b>HMO- COMPREHEALTH</b> |  |                       |                 |                           |               |                        |               |                         |                      |        |         |
| 11                       | <b>HMO-30/50/1000</b>                                  |                       |                 |                           |               |                        |               |                         |                      |        |         |
|                          | \$30 PCP / \$50 Specialist Copay<br>\$0 Copay Children | \$1000 Hospital Copay | Referral        | \$15 Generic Only         | Comprehealth  | 267.83                 | 824.07        | 267.83                  | 642.77               | 535.11 | 867.76  |
| 12                       | <b>HMO-30/50/500</b>                                   |                       |                 |                           |               |                        |               |                         |                      |        |         |
|                          | \$30 PCP / \$50 Specialist Copay<br>\$0 Copay Children | \$500 Hospital Copay  | Referral        | \$15 Generic Only         | Comprehealth  | 297.66                 | 915.85        | 297.66                  | 714.36               | 594.70 | 964.41  |
| 13                       | <b>HMO-25/40/500A</b>                                  |                       |                 |                           |               |                        |               |                         |                      |        |         |
|                          | \$25 PCP / \$40 Specialist Copay<br>\$0 Copay Children | \$500 Hospital Copay  | Referral        | \$25 Generic/\$35 Brand   | Comprehealth  | 338.95                 | 1042.93       | 338.95                  | 813.49               | 677.22 | 1098.21 |
| 14                       | <b>HMO-25/40/500</b>                                   |                       |                 |                           |               |                        |               |                         |                      |        |         |
|                          | \$25 PCP / \$40 Specialist Copay<br>\$0 Copay Children | \$500 Hospital Copay  | Referral        | \$0 Generic<br>\$30 Brand | Comprehealth  | 410.39                 | 1262.73       | 410.39                  | 984.93               | 819.95 | 1329.67 |
| 15                       | <b>HMO-20/25/200</b>                                   |                       |                 |                           |               |                        |               |                         |                      |        |         |
|                          | \$20 PCP / \$25 Specialist Copay<br>\$0 Copay Children | \$200 Hospital Copay  | Referral        | \$15 Generic Only         | Comprehealth  | 362.67                 | 1115.88       | 362.67                  | 870.40               | 724.59 | 1175.04 |

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**NOTES:**

- 1) EH PPO & EPO requires 50% participation in EH products (class carve-outs allowed) and a minimum of 2 participants. Participation requirement can include participation in HIP and Comprehealth.
- 2) NY Metro (Comprehealth) is a limited network.

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| 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  |
| <b>HIP</b>          |   |                 |                            |              |                        |          |                         |                  |                      |         |
| <b>COST SHARING</b> |   |                 |                            |              |                        |          |                         |                  |                      |         |
| 1                   | <b>EPO 30/50 1000A Select</b><br>\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services<br>90% coin, \$1000 coin max.  | No Referral     | <b>\$15 (Generic Only)</b> | SELECT PRIME | 331.12                 | 1006.52  | 331.12                  | 784.37           | 661.85               | 1074.51 |
| 2                   | <b>EPO 30/50 1000 Select</b><br>\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services<br>90% coin, \$1000 coin max.   | No Referral     | <b>\$20/30/50</b>          | SELECT PRIME | 386.67                 | 1177.43  | 386.67                  | 917.69           | 772.83               | 1254.48 |
| 3                   | <b>EPO 25/1000 Select</b><br>\$25 Copay, \$1000 ded. hospital based services.<br>90% coin, \$500 coin max.  | No Referral     | <b>\$20/30/50</b>          | SELECT PRIME | 414.44                 | 1262.88  | 414.44                  | 984.34           | 828.31               | 1344.45 |
| 4                   | <b>PPO 15/1000 Select</b><br><b>In Network</b><br>\$15 Copay, \$1000 ded. hospital based services<br>90% coin, \$500 coin max.<br><b>Out of Network</b><br>\$1000/2000 Deductible<br>80% to \$3000/6000 coin max. | No Referral     | <b>\$15/30/50</b>          | SELECT PRIME | 666.11                 | 2037.27  | 666.11                  | 1588.38          | 1331.17              | 2159.89 |
| <b>POS PLANS</b>    |   |                 |                            |              |                        |          |                         |                  |                      |         |
| 5                   | <b>POS 20/1000</b><br><b>In Network</b><br>\$20 Copay<br>\$250 Hospital Copay<br><b>Out of Network</b><br>\$1000/2000 Deductible<br>70% to \$2000/\$4000 OOP  | Referral        | <b>\$7/30/50</b>           | PRIME        | 739.32                 | 2,157.17 | 739.32                  | 1774.35          | 1477.14              | 2395.40 |

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