



CONSUMER DRIVEN  
RENEWAL RATES

DATED: 8/9/10

Please visit our web site, [www.LIAHealthAlliance.com](http://www.LIAHealthAlliance.com), and read the benefit summaries before finalizing your selections.

SHEET PLAN #	<b>ATLANTIS</b>				MONTHLY 4 TIER RATES				
	COPAY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
1	<b>POS 20/2000 HRA Option #1</b>								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$10 Generic Brand Name \$250 ded. \$25 Copay, Max. \$2000	Atlantis	450.78	901.56	906.52	1387.50
2	<b>POS 20/2000 HRA Option #2</b>								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$250 Deductible \$7/30/50	Atlantis	468.56	937.12	942.27	1442.23
3	<b>POS 20/2000 HRA Option #3</b>								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$100 Deductible \$7/30/50	Atlantis	476.52	953.04	958.28	1466.73
4	<b>POS 20/2000 HRA Option #4</b>								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$7/30/50	Atlantis	483.93	967.86	973.18	1489.54

Note:

The Rates contained in this document have been filed with the NYS Insurance Department but have not received final approval and therefore are subject to change.

Atlantis POS Rates are available for Renewals Only.

DATED: 12/3/10 (11/22/10) (9/9/10)

Please visit our web site, [www.LIAHealthAlliance.com](http://www.LIAHealthAlliance.com), and read the benefit summaries before finalizing your selections.

RATE SHEET PLAN #	<b>EMBLEM HEALTH</b>				MONTHLY TWO TIER RATES		MONTHLY FOUR TIER RATES				
	COPAY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(rn)	FAMILY	
<b>HSA HIGH DEDUCTIBLE EPO PLANS</b>											
1	<b>EPO 1200 90% INDEXED*</b>										
	<u>In Network</u> Deductible \$1200/\$2400 90% Coinsurance \$5800/\$11600 OOP	No Referral	Subject to plan deductible RX \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order	National	448.73	1301.29	448.73	1076.93	830.14	1346.16	
2	<b>EPO 2500 70%</b>										
	<u>In Network</u> Deductible \$2500/\$5000 70% Coinsurance \$4750/\$9500 OOP	No Referral	Subject to plan deductible RX \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order	National	323.88	939.28	323.88	777.35	599.20	971.68	
3	<b>EPO 3000 100% INDEXED*</b>										
	<u>In Network</u> Deductible \$3,000/\$5,950 100%	No Referral	Covered in full after deductible	National	336.97	977.23	336.97	808.72	623.4	1010.91	
4	<b>EPO 5800 100% INDEXED*</b>										
	<u>In Network</u> Deductible \$5,800/\$11,600 100%	No Referral	Covered in full after deductible	National	247.14	716.71	247.14	593.15	457.22	741.42	
5	<b>EPO 1500 100% INDEXED*</b>										
	<u>In Network</u> Deductible \$1500/\$3000 100%	No Referral	Covered in full after deductible	National	491.23	1424.58	491.23	1178.95	908.78	1473.69	
<b>NON HSA HIGH DEDUCTIBLE EPO PLAN</b>											
6	<b>EPO 10,000 100%</b>										
	<u>In Network</u> EPO \$10,000-Non HSA Deductible \$10,000/\$20,000 100%	No Referral	Covered in full after deductible	National	170.76	495.200	170.76	409.8	315.89	512.27	
<b>HSA HIGH DEDUCTIBLE PPO PLANS WITH SHARED DEDUCTIBLES</b>											
7	<b>PPO 1200 80% INDEXED*</b>										
	<u>In Network</u> Deductible \$1200/\$2400 80% Coinsurance \$3150/\$6300 OOP	<u>Out of Network</u> Deductible \$2200/\$4400 60% Coinsurance \$6200/\$12400 OOP	No Referral	Subject to plan deductible \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order (voluntary)	National	574.07	1664.83	574.07	1377.79	1062.04	1722.21
8	<b>PPO 2500 100%</b>										
	<u>In Network</u> Deductible \$2500/\$5000 100%	<u>Out of Network</u> Deductible \$5,000/\$10,000 30% Coinsurance \$7,000/\$14,000 OOP Max	No Referral	Covered in full after deductible	National	504.99	1464.48	504.99	1211.97	934.24	1514.97
9	<b>PPO 2500 80%</b>										
	<u>In Network</u> Deductible \$2500/\$5000 80% Coinsurance \$4500/\$9000 OOP	<u>Out of Network</u> Deductible \$5000/\$10000 60% Coinsurance \$9000/\$18000 OOP	No Referral	Covered in full after deductible	National	451.37	1308.94	451.37	1083.25	835.01	1354.07
10	<b>PPO 5000 100%</b>										
	<u>In Network</u> Deductible \$5000/\$10000 100% to \$5000/\$10,000 oop Max	<u>Out of Network</u> Deductible \$10,000/\$20,000 80% to \$12,000/\$24,000 OOP Max	No Referral	Covered in full after deductible	National	334.77	970.82	334.77	803.44	619.32	1004.31

Rates are subject to NYS Insurance Department Approval.

**NOTES:**

\* **INDEXED** - deductible and out of pocket max will increase in January according to IRS guidelines.