

RELEASE DATE: 1/24/11



**TRADITIONAL
NEW BUSINESS RATES**

1st QUARTER 2011

DATED: 1/24/11

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

RATE SHEET PLAN #	ATLANTIS									
	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
HMO PLANS										
1	HMO 25/40A \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0 Generic	Atlantis	380.63	976.32	380.63	761.26	765.45	1171.58
2	HMO 20A \$20 Copay \$500 Hospital Copay	No Referral	\$0 Generic	Atlantis	397.77	1020.28	397.77	795.54	799.92	1224.34
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0/30/50	Atlantis	415.46	1065.65	415.46	830.92	835.49	1278.79
4	HMO 20 \$20 Copay \$500 Hospital Copay	No Referral	\$20/30/40	Atlantis	425.20	1090.64	425.20	850.40	855.08	1308.77
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay	No Referral	\$0/30/50	Atlantis	472.60	1212.22	472.60	945.20	950.40	1454.66
6	HMO 20 Plus \$20 Copay No Hospital Copay	No Referral	\$20/30/40	Atlantis	485.90	1246.33	485.90	971.80	977.14	1495.60

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1st QUARTER 2011

REVISED: 1/21/11 (12/15/10) (11/30/10) (11/22/10)

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RATE SHEET	Monthly Two Tier Rates										Monthly Four Tier Rates		
	PLAN # EMBLEM HEALTH		COPAY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
COST SHARING													
1	CS EPO 40/1000C		\$40 Copay \$0 Copay Children	\$1000/3000 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 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	393.51	1145.50	393.51	944.41	731.91	1185.70
2	CS EPO 40/2000B		\$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 \$3,000 threshold; 50% thereafter Mail Order Unlimited	National	387.11	1126.98	387.11	929.09	720.11	1166.56
3	CS EPO 40/2000A		\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP	No Referral	\$15 GENERIC ONLY	National	303.35	882.17	303.35	725.52	565.84	914.67
NON COST SHARING													
4	EPO 40/1000		\$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	498.96	1451.38	498.96	1197.51	927.04	1502.11
5	EPO 40/1000A		\$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$15 GENERIC ONLY	National	385.33	1119.95	385.33	922.28	717.50	1160.62
6	EPO 40/1000B		\$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	446.51	1299.28	446.51	1071.65	830.01	1344.77
7	PPO 40/500/3000		<u>In Network</u> \$40 Copay \$0 Copay Children \$500 x 3 Hospital Copay; \$500 Amb.	<u>Out of Network</u> \$3000/9000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR	No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			682.19	1637.26	1265.99	2051.78
8	PPO 30/300/2000		<u>In Network</u> \$30 Copay \$0 Copay Children \$300 x 5 Hospital Copay; \$250 Amb.	<u>Out of Network</u> \$2000/6000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR	No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National			791.98	1900.75	1469.10	2381.15



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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	
NON COST SHARING (continued)											
9	PPO 30/300/2000A		No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			740.06	1776.17	1373.08	2225.43
	<u>In Network</u> \$30 Copay \$0 Copay Children \$300 x 5 Hospital Copay; \$250 Amb.	<u>Out of Network</u> \$2000/6000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR									
HMO- COMPREHEALTH											
10	HMO-30/50/1000		Referral	\$15 Generic Only	Comprehealth	273.20	799.68	273.20	643.14	524.60	850.72
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay									
11	HMO-30/50/500		Referral	\$15 Generic Only	Comprehealth	303.62	888.69	303.62	714.73	583.02	945.47
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
12	HMO-25/40/500A		Referral	\$25 Generic/\$35 Brand	Comprehealth	345.82	1013.11	345.82	814.81	664.08	1076.88
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
13	HMO-25/40/500		Referral	\$0 Generic Brand \$30, Non Pref \$50	Comprehealth	419.05	1231.62	419.05	990.53	804.69	1304.89
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
14	HMO-20/25/200		Referral	\$15 Generic Only	Comprehealth	369.96	1082.69	369.96	870.77	710.37	1151.98
	\$20 PCP / \$25 Specialist Copay \$0 Copay Children	\$200 Hospital Copay									

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NOTES:

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



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RATE SHEET PLAN #	HIP										
	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	
COST SHARING											
1	EPO 30/50 1000A Select PESLT2253 \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	No Referral	\$15 (Generic Only)	SELECT PRIME	331.12	976.16	331.12	784.37	636.11	1032.72	
2	EPO 30/50 1000 Select PESLT2254 \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	No Referral	\$20/30/50	SELECT PRIME	386.67	1141.92	386.67	917.69	742.78	1205.70	
3	EPO 25/1000 Select PESLT2051 \$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	414.44	1224.79	414.44	984.34	796.10	1292.17	
4	PPO 15/1000 Select PFLST5026 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 PRIME	666.11	1975.82	666.11	1588.38	1279.40	2075.89	
5	PPO 30/50 2000 Select PFSLT6107 In Network \$30 PCP/\$50 Specialist Copay, \$2000 ded hospital based services 80% coin, \$5,000 coin max. Out of Network \$4000/8000 Deductible 60% coins to \$10,000/20,000 coins max.	No Referral	Not Covered	SELECT PRIME			445.36	1058.29	885.50	1388.52	
POS PLANS											
6	POS 20/1000 PPSTD2363 In Network \$20 Copay \$250 Hospital Copay Out of Network \$1000/2000 Deductible 70% to \$2000/\$4000 OOP	Referral	\$7/30/50	PRIME	754.45	2,097.95	754.45	1779.30	1448.77	2349.39	

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