

**RENEWAL RATES (existing groups)**

REVISED: 1/24/11 (11/3/10)

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

RATE SHEET PLAN #	HIP	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>COST SHARING</b>											
1	<b>EPO 30/50 1000A Select</b> PESLT2253D	\$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	<b>EPO 30/50 1000 Select</b> 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	<b>EPO 25/1000 Select</b> 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	<b>EPO 15/1000 Select</b> PESLT2053	\$15 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	431.99	1277.16	431.99	1026.46	829.81	1346.82
5*	<b>PPO 15/1000 Select</b> PFSLT5026	<b>In Network</b> \$15 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$15/30/50	SELECT PRIME	666.11	1975.82	666.11	1588.38	1279.40	2075.89
		<b>Out of Network</b> \$1000/2000 Deductible 80% to \$3000/6000 coin max.									
6*	<b>PPO 30/50 1000 Select</b> PFSLT5087	<b>In Network</b> PCP \$30 / \$50 Specialist Copay, \$1000 ded hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	602.14	1784.92	602.14	1434.84	1156.55	1876.69
		<b>Out of Network</b> \$1000/2000 Ded. 80% to \$3000/6000 coin max.									
7*	<b>PPO 25/1000 Select</b> PFSLT5008	<b>In Network</b> \$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	635.50	1884.46	635.50	1514.90	1220.60	1980.55
		<b>Out of Network</b> \$1000/2000 Deductible 80% to \$3000/6000									
8	<b>PPO 30/50 2000 Select**</b> PFSLT6107	<b>In Network</b> \$30 PCP/\$50 Specialist Copay, \$2000 ded hospital based services. 80% coin, \$5,000 coin max.	No Referral	Not Covered	SELECT PRIME			445.36	1058.29	885.50	1388.52
		<b>Out of Network</b> \$4000/8000 Deductible 60% coins to \$10,000/20,000 coins max.									
<b>HMO PLANS</b>											
9*	<b>HMO SUPER VALUE</b> PHSTD4912	\$20 Copay \$500 Hospital Copay	Referral	\$100 Deductible \$10 (Generic Only) Name Brand Discount	PRIME	559.47	1553.01	559.47	1317.17	1074.32	1742.15
10*	<b>HMO 25/40A</b> PHSTD4057	\$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	582.58	1619.68	582.58	1373.71	1118.70	1814.12
11*	<b>HMO VALUE</b> PHSTD4913	\$20 Copay \$500 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	626.60	1742.94	626.60	1478.27	1203.22	1951.17
12*	<b>HMO 20</b> PHSTD4914	\$20 Copay \$250 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	648.08	1802.58	648.08	1528.83	1244.51	2018.09
13*	<b>HMO 5</b> PHSTD4915	\$5 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	680.43	1892.47	680.43	1605.07	1306.65	2118.86
14*	<b>HMO 15</b> PHSTD4917	\$15 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	666.06	1852.60	666.06	1571.26	1279.07	2074.12
15*	<b>HMO 10</b> PHSTD4916	\$10 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	674.78	1876.83	674.78	1591.80	1295.82	2101.31
<b>POS PLANS</b>											
16	<b>POS 20/1000</b> PPSTD2363	<b>In Network</b> \$20 Copay \$250 Hospital Copay	Referral	\$7/30/50	PRIME	754.45	2097.95	754.45	1779.30	1448.77	2349.39
		<b>Out of Network</b> \$1000/2000 Deductible 70% to \$2000/\$4000 OOP									

Rates are subject to NYS Insurance Department Approval

NOTE: Super Value HMO/EPO Prescription benefit is \$10 Mandatory Generic with a value added feature - Discount for Brand Name Drugs through participating pharmacies

\* THE 10 PLANS ABOVE WITH AN \* ARE ONLY AVAILABLE FOR GROUPS WHO CURRENTLY HAVE EMPLOYEES ENROLLED IN

\*\* Replacement plan for SmartStart enrollees.