

RELEASE DATE: 3/7/11



**TRADITIONAL
NEW BUSINESS RATES**

2nd QUARTER 2011

DATED: 2/10/11

Please visit our web site, 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
HMO PLANS										
1	HMO 25/40A \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0 Generic	Atlantis	403.06	1033.85	403.06	806.12	810.55	1240.62
2	HMO 20A \$20 Copay \$500 Hospital Copay	No Referral	\$0 Generic	Atlantis	421.25	1080.51	421.25	842.50	847.13	1296.61
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0/30/50	Atlantis	440.57	1130.06	440.57	881.14	885.99	1356.07
4	HMO 20 \$20 Copay \$500 Hospital Copay	No Referral	\$20/30/40	Atlantis	450.91	1156.58	450.91	901.82	906.78	1387.90
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay	No Referral	\$0/30/50	Atlantis	501.20	1285.58	501.20	1002.40	1007.91	1542.69
6	HMO 20 Plus \$20 Copay No Hospital Copay	No Referral	\$20/30/40	Atlantis	515.31	1321.77	515.31	1030.62	1036.29	1586.12

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RATE SHEET	EMBLEM HEALTH											
	COPAY			Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
PLAN #												
COST SHARING												
1	CS EPO 40/1000C			No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	428.92	1248.60	428.92	1029.41	797.78	1292.41
	\$40 Copay	\$1000/3000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP										
2	CS EPO 40/2000B			No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$3,000 threshold; 50% thereafter Mail Order Unlimited	National	421.96	1228.41	421.96	1012.71	784.92	1271.55
	\$40 Copay	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP										
3	CS EPO 40/2000A			No Referral	\$15 GENERIC ONLY	National	330.66	961.57	330.66	790.82	616.76	996.99
	\$40 Copay	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP										
4	CS EPO 30/2000			No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	473.60	1378.17	473.60	1136.63	880.46	1426.45
	\$30 Copay	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP										
NON COST SHARING												
5	EPO 40/1000			No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	543.87	1582.01	543.87	1305.28	1010.47	1637.30
	\$40 Copay	\$1000 Hospital Copay										
6	EPO 40/1000A			No Referral	\$15 GENERIC ONLY	National	420.01	1220.76	420.01	1005.28	782.07	1265.08
	\$40 Copay	\$1000 Hospital Copay										
7	EPO 40/1000B			No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	486.69	1416.23	486.69	1168.09	904.71	1465.80
	\$40 Copay	\$1000 Hospital Copay										
8	PPO 40/500/3000			No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			743.58	1784.61	1379.93	2236.44
	<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										
9	PPO 30/300/2000			No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National			863.26	2071.82	1601.32	2595.45
	<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										



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	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
	Monthly Two Tier Rates					Monthly Four Tier Rates					
NON COST SHARING (continued)											
10	PPO 30/300/2000A		No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			806.66	1936.02	1496.66	2425.72
	In Network \$30 Copay \$0 Copay Children \$300 x 5 Hospital Copay; \$250 Amb.	Out of Network \$2000/6000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR									
HMO- COMPREHEALTH											
11	HMO-30/50/1000		Referral	\$15 Generic Only	Comprehealth	284.43	790.23	284.43	597.30	546.18	885.72
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay									
12	HMO-30/50/500		Referral	\$15 Generic Only	Comprehealth	316.10	878.22	316.10	663.81	606.99	984.34
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
13	HMO-25/40/500A		Referral	\$25 Generic/\$35 Brand	Comprehealth	360.04	1000.31	360.04	756.10	691.37	1121.16
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
14	HMO-25/40/500		Referral	\$0 Generic Brand \$30, Non Pref \$50	Comprehealth	436.27	1212.10	436.27	916.18	837.76	1358.54
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
15	HMO-20/25/200		Referral	\$15 Generic Only	Comprehealth	385.14	1070.04	385.14	808.80	739.58	1199.93
	\$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 \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	PESLT2253	No Referral	\$15 (Generic Only)	SELECT PRIME	361.82	988.23	361.82	757.24	695.11	1128.32
2	EPO 30/50 1000 Select \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	PESLT2254	No Referral	\$20/30/50	SELECT PRIME	424.46	1160.33	424.46	888.78	815.39	1323.38
3	EPO 25/1000 Select \$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	PESLT2051	No Referral	\$20/30/50	SELECT PRIME	455.00	1244.24	455.00	952.91	874.03	1418.49
4	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.	PFLST5026	No Referral	\$15/30/50	SELECT PRIME	680.35	1863.38	680.35	1426.14	1306.78	2120.21
5	PPO 30/50 2000 Select 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.	PFLST6107	No Referral	Not Covered	SELECT PRIME			436.39	913.83	838.30	1360.52
POS PLANS											
6	POS 20/1000 In Network \$20 Copay \$250 Hospital Copay Out of Network \$1000/2000 Deductible 70% to \$2000/\$4000 OOP	PPSTD2363	Referral	\$7/30/50	PRIME	785.40	2182.07	785.40	1649.33	1508.20	2445.74

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