

RELEASE DATE: 7/8/11



**TRADITIONAL
NEW BUSINESS RATES**

**3rd QUARTER 2011
July - Aug - Sept**

DATED: 5/6/11

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

NOTE: 2Q RATES ARE GOOD THROUGH AUGUST 2011.
Rates are subject to NYS Insurance Department approval.

**TRADITIONAL
NEW BUSINESS RATES**

3rd QUARTER 2011

DATED: 6/8/11

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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
	COST SHARING											
1	CS EPO 40/2500/80			No Referral	\$15 Generic Only	National	348.33	1012.91	348.33	833.11	649.64	1083.46
	\$40 Copay	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$4,500/13,500 OOP										
	\$0 Copay Children											
2	CS EPO 40/2500/80 A			No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	423.77	1233.87	423.77	1017.06	788.45	1319.49
	\$40 Copay	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$4,500/13,500 OOP										
	\$0 Copay Children											
	NON COST SHARING											
3	EPO 40/1000/750			No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	512.25	1490.54	512.25	1229.44	952.16	1551.71
	\$40 Copay	\$1000 Hospital Copay \$750 Ambulatory										
	\$0 Copay Children											
	\$100 ER											
4	PPO 40/500/5000			No Referral	\$10 Generic, \$50 ded Brand \$25, Non Pref \$50	National	820.34	2383.91	820.34	1968.81	1522.08	2548.82
	In Network	Out of Network										
	\$40 Copay	\$5,000/15,000 Annual Deductible 70% to \$8,000/24,000 OOP 70th percentile UCR										
	\$0 Copay Children											
	\$500 x 3 Hospital Copay											
	HMO- COMPREHEALTH											
5	HMO-30/50/1000			Referral	\$15 Generic Only	Comprehealth	292.95	856.10	292.95	688.43	562.55	912.25
	\$30 PCP / \$50 Specialist Copay	\$1000 Hospital Copay										
	\$0 Copay Children											
6	HMO-30/50/1000A			Referral	\$15 Generic \$100 ded Brand \$35, Non Pref \$75	Comprehealth	339.77	992.93	339.77	798.46	652.46	1058.04
	\$30 PCP / \$50 Specialist Copay	\$1000 Hospital Copay										
	\$0 Copay Children											

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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	371.91	1097.88	371.91	882.27	714.47	1159.74
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	436.43	1290.41	436.43	1,037.12	838.37	1360.66
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	467.89	1384.29	467.89	1112.62	898.77	1458.61
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	700.39	2078.12	700.39	1670.65	1345.26	2182.64
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.	PFSLTB107	No Referral	Not Covered	SELECT PRIME			448.71	1066.59	861.94	1398.90
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	808.98	2247.59	808.98	1901.11	1553.48	2519.16

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