

RENEWAL RATES (existing groups)

DATED: 5/19/11

Please visit our web site, 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
COST SHARING											
1	EPO 30/50 1000A Select	PESLT2253D	No Referral	\$15 (Generic Only)	SELECT PRIME	371.91	1097.88	371.91	882.27	714.47	1159.74
	\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.										
2	EPO 30/50 1000 Select	PESLT2254	No Referral	\$20/30/50	SELECT PRIME	436.43	1290.41	436.43	1,037.12	838.37	1360.66
	\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.										
3	EPO 25/1000 Select	PESLT2051	No Referral	\$20/30/50	SELECT PRIME	467.89	1384.29	467.89	1112.62	898.77	1458.61
	\$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.										
4	EPO 15/1000 Select	PESLT2053	No Referral	\$20/30/50	SELECT PRIME	487.78	1443.66	487.78	1160.37	936.97	1520.56
	\$15 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.										
5*	PPO 15/1000 Select	PFSLT5026	No Referral	\$15/30/50	SELECT PRIME	700.39	2078.12	700.39	1670.65	1345.26	2182.64
	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.									
6*	PPO 30/50 1000 Select	PFSLT5087	No Referral	\$20/30/50	SELECT PRIME	633.06	1877.18	633.06	1509.04	1215.97	1972.97
	In Network PCP \$30 / \$50 Specialist Copay, \$1000 ded hospital based services 90% coin, \$500 coin max.	Out of Network \$1000/2000 Ded. 80% to \$3000/6000 coin max.									
7*	PPO 25/1000 Select	PFSLT5008	No Referral	\$20/30/50	SELECT PRIME	667.62	1980.32	667.62	1591.98	1282.33	2080.59
	In Network \$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	Out of Network \$1000/2000 Deductible 80% to \$3000/6000									
8	PPO 30/50 2000 Select**	PFSLT6107	No Referral	Not Covered	SELECT PRIME			448.71	1066.59	861.94	1398.90
	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.									
HMO PLANS											
9*	HMO SUPER VALUE	PHSTD4912	Referral	\$100 Deductible \$10 (Generic Only) Name Brand Discount	PRIME	599.88	1666.65	599.88	1409.71	1151.95	1868.03
	\$20 Copay	\$500 Hospital Copay									
10*	HMO 25/40A	PHSTD4057	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	624.66	1735.50	624.66	1467.96	1199.53	1945.19
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay									
11*	HMO VALUE	PHSTD4913	Referral	\$50 Deductible \$7/30/50	PRIME	671.85	1866.60	671.85	1578.84	1290.16	2092.14
	\$20 Copay	\$500 Hospital Copay									
12*	HMO 20	PHSTD4914	Referral	\$50 Deductible \$7/30/50	PRIME	694.89	1930.62	694.89	1632.98	1334.41	2163.89
	\$20 Copay	\$250 Hospital Copay									
13*	HMO 5	PHSTD4915	Referral	\$7/30/50	PRIME	729.60	2027.06	729.60	1714.55	1401.05	2271.97
	\$5 Copay	No Hospital Copay									
14*	HMO 15	PHSTD4917	Referral	\$7/30/50	PRIME	714.19	1984.24	714.19	1678.33	1371.45	2223.99
	\$15 Copay	No Hospital Copay									
15*	HMO 10	PHSTD4916	Referral	\$7/30/50	PRIME	723.54	2010.22	723.54	1700.30	1389.43	2253.10
	\$10 Copay	No Hospital Copay									
POS PLANS											
16	POS 20/1000	PPSTD2363	Referral	\$7/30/50	PRIME	808.98	2247.59	808.98	1901.11	1553.48	2519.16
	In Network \$20 Copay \$250 Hospital Copay	Out of Network \$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.