

RELEASE DATE: 11/8/11



**TRADITIONAL
NEW BUSINESS RATES**

4th QUARTER 2011

DATED: 8/22/11

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	423.90	1087.30	423.90	847.80	852.46	1304.76
2	HMO 20A \$20 Copay \$500 Hospital Copay	No Referral	\$0 Generic	Atlantis	442.98	1136.24	442.98	885.96	890.83	1363.49
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0/30/50	Atlantis	461.70	1184.26	461.70	923.40	928.48	1421.11
4	HMO 20 \$20 Copay \$500 Hospital Copay	No Referral	\$20/30/40	Atlantis	472.54	1212.07	472.54	945.08	950.28	1454.48
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay	No Referral	\$0/30/50	Atlantis	525.28	1347.34	525.28	1050.56	1056.34	1616.81
6	HMO 20 Plus \$20 Copay No Hospital Copay	No Referral	\$20/30/40	Atlantis	540.06	1385.25	540.06	1080.12	1086.06	1662.30

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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 40/2500/80 \$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$2,000/6,000 OOP	No Referral	\$15 Generic Only	National	362.26	1,053.43	362.26	866.43	675.62	1126.79
2	CS EPO 40/2500/80 A \$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$2,000/6,000 OOP	No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	440.72	1283.22	440.72	1057.70	819.98	1372.26
NON COST SHARING											
3	EPO 40/1000/750 \$40 Copay \$0 Copay Children \$100 ER	\$1000 Hospital Copay \$750 Ambulatory	No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	532.74	1550.16	532.74	1278.61	990.25	1613.78
4	PPO 40/500/5000 In Network \$40 Copay \$0 Copay Children \$500 x 3 Hospital Copay	Out of Network \$5,000/15,000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR	No Referral	\$10 Generic, \$50 ded Brand \$25, Non Pref \$50	National			853.15	2047.56	1582.96	2650.77
HMO- COMPREHEALTH											
5	HMO-30/50/1000 \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	301.71	881.80	301.71	709.10	579.42	939.60
6	HMO-30/50/1000A \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic \$100 ded Brand \$35, Non Pref \$75	Comprehealth	349.93	1022.72	349.93	822.42	672.02	1089.76

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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.



4th QUART

TRADITIONAL
NEW BUSINESS RATES

DATED: 10/31/11

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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)	
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	382.29	1128.88	382.29	907.21	734.41	
2	EPO 30/50 1000B Select 56 PESLT2381 \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	No Referral	\$50 Ded. \$20/30/50	SELECT PRIME	445.87	1318.61	445.87	1059.81	856.50	
3	PPO 30/50 1000 Select 57 PFSLT6186 <u>In Network</u> \$30 Copay, \$1000 ded. hospital based services 90% coin, \$1000 coin max. <u>Out of Network</u> \$1000/2000 Deductible 70% to \$3000/6000 coin max.	No Referral	\$50 Ded. \$20/30/50	SELECT PRIME	637.90	1891.64	637.90	1520.66	1225.25	
4	PPO 30/50 2000A Select 62 PFSLTA038 <u>In Network</u> \$30 PCP/\$50 Specialist Copay, \$2000 ded hospital based services 80% coin, \$3,500 coin max. <u>Out of Network</u> \$2500/5000 Deductible 70% coins to \$4,000/8,000 coins max.	No Referral	Not Covered	SELECT PRIME	501.98	1486.04	501.98	1194.45	964.25	

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