

RELEASE DATE: 11/8/11



TRADITIONAL

4th QUARTER 2011

RENEWAL RATES

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)
HMO PLANS										
1	HMO 25/40A \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0 Generic Only	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 Only	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
POS PLANS										
7	POS 25/40 2000A In Network: \$25 PCP/\$40 Spec Copay, \$500 Hospital Copay Out of Network: \$2000/4000 Deductible, 70% to \$5,000/\$10,000 Max OOP	No Referral	\$0 Generic Only	Atlantis	493.94	1266.96	493.94	987.88	993.31	1520.35
8	POS 20/2000 In Network: \$20 Copay, \$500 Hospital Copay Out of Network: \$2000/4000 Deductible, 70% to \$5,000/\$10,000 Max OOP	No Referral	\$0 Generic Only	Atlantis	510.70	1309.95	510.70	1021.40	1027.02	1571.93
9	POS 25/40 2000 In Network: \$25 PCP/\$40 Spec Copay, \$500 Hospital Copay Out of Network: \$2000/4000 Deductible, 70% to \$5,000/\$10,000 Max OOP	No Referral	\$20/30/40	Atlantis	523.50	1342.78	523.50	1047.00	1052.76	1611.33
10	POS 20/1000 In Network: \$20 Copay, \$0 Hospital Copay Out of Network: \$1000/2500 Deductible, 70% to \$3,000/\$7,500 Max OOP	No Referral	\$0/30/50	Atlantis	644.15	1652.24	644.15	1288.30	1295.39	1982.69
11	POS 25/40 1000 Plus In Network: \$25 PCP/\$40 Spec Copay, \$0 Hospital Copay Out of Network: \$1000/2500 Deductible, 70% to \$3,000/\$7,500 Max OOP	No Referral	\$0/\$30/\$50	Atlantis	613.30	1573.11	613.30	1226.60	1233.35	1887.74
12	POS 20/500 In Network: \$20 Copay, \$0 Hospital Copay Out of Network: \$500/1250 Deductible, 70% to \$3,000/\$7,500 Max OOP	No Referral	\$20/30/40	Atlantis	705.76	1810.27	705.76	1411.52	1419.28	2172.33

Rates are subject to NYS Insurance Department Approval

NOTE: Atlantis POS plans are available for existing enrollees only.

The above rates include adjustments for Health Care Reform (PPACA).



TRADITIONAL
RENEWAL RATES

4th QUARTER 2011

DATED: 11/8/11

Please visit our web site, www.LIAHealthAlliance.com, and read the benefit summaries before finalizing your selections

RATE SHEET	EMBLEM HEALTH										
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(REN)	FAMILY
PLAN #	Monthly Two Tier Rates					Monthly Four Tier Rates					
COST SHARING											
1*	CS EPO 40/2500/80		No Referral	\$15 Generic Only	National	362.26	1,053.43	362.26	866.43	675.62	1126.79
	\$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$2,000/6,000 OOP									
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	440.72	1283.22	440.72	1057.70	819.98	1372.26
	\$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$2,000/6,000 OOP									
3	CS EPO 40/1000A		No Referral	None	National	402.23	1171.62	402.23	965.39	748.78	1212.82
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
4	CS EPO 40/1000C		No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	463.93	1,350.48	463.93	1,113.41	862.87	1397.87
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
5	CS EPO 40/2000B		No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$3,000 threshold; 50% thereafter Mail Order Unlimited	National	456.39	1328.65	456.39	1095.35	848.97	1375.30
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
6	CS EPO 40/2000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	491.62	1430.75	491.62	1179.84	914.12	1480.94
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
7	CS EPO 40/2000A		No Referral	\$15 GENERIC ONLY	National	357.64	1040.03	357.64	855.36	667.09	1078.34
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
8	CS EPO 40/1000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	551.38	1604.08	551.38	1323.29	1024.67	1660.21
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
9	CS EPO 40/1000B		No Referral	\$15 GENERIC ONLY	National	417.40	1213.36	417.40	998.81	777.64	1257.61
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
10	CS EPO 30/500		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	598.93	1741.90	598.93	1437.34	1112.60	1802.81
	\$30 Copay \$0 Copay Children	\$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									



TRADITIONAL

4th QUARTER 2011

RENEWAL RATES (continued)

RATE SHEET PLAN #	EMBLEM HEALTH		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	
NON COST SHARING											
11	EPO 40/1000 \$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	588.26	1711.09	588.26	1411.79	1092.92	1770.91
12	EPO 40/1000A \$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$15 GENERIC ONLY	National	454.28	1320.37	454.28	1087.31	845.89	1368.31
13	EPO 40/1000B \$40 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	526.41	1531.79	526.41	1263.40	978.53	1585.41
14*	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
15*	PPO 40/500/5000 <u>In Network</u> \$40 Copay \$0 Copay Children \$500 x 3 Hospital Copay	<u>Out of Network</u> \$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
16	EPO 30/1000 \$30 Copay \$0 Copay Children	\$1000 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	630.97	1834.91	630.97	1514.28	1171.92	1899.03
17	EPO 30/500 \$30 Copay \$0 Copay Children	\$500 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	683.45	1987.11	683.45	1640.22	1268.98	2056.45

RATE SHEET	EMBLEM HEALTH										
	Monthly Two Tier Rates		Monthly Four Tier Rates								
PLAN #	COPAY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
HMO- COMPREHEALTH											
18*	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
19*	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
20	HMO-30/50/500 \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	335.32	979.97	335.32	788.06	643.94	1044.23
21	HMO-25/40/500A \$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$25 Generic/\$35 Brand	Comprehealth	381.97	1116.23	381.97	897.62	733.48	1189.43
22	HMO-25/40/500 \$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$0 Generic \$30 Brand	Comprehealth	462.83	1352.54	462.83	1087.65	888.76	1441.23

Rates are subject to NYS Insurance Department approval.

NOTES:

- 1) EH plans with prescription retail maximums are no longer available and have been replaced with corresponding plans without retail maximums. Additional plans with RX thresholds may also be selected.
- 2) NY Metro (Comprehealth) is a limited network.
- 3) EH members may renew in their existing plan ONLY or in those plans available for new business *.
- 4) New members to EH from existing groups (coming from Atlantis) may renew into plans available for new business *.
- 5) Existing EH members who want to make changes on renewal may only change into plans available for new business *.

TRADITIONAL
RENEWAL RATES (existing groups)

4th QUARTER 2011

DATED: 8/24/11

Please visit our web site, www.LIAHealthAlliance.com, and read the benefit summaries before finalizing your selections.

RATE SHEET PLAN #	EMBLEM HEALTH (formerly GHI renewals)																	
	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								
NON COST SHARING																		
1	PPO 30/1000G (2 tier available for existing enrollees only)	No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National	1047.66	3043.30	1047.66	2514.35	1942.78	3149.07								
	<table border="0"> <tr> <td><u>In Network</u></td> <td><u>Out of Network</u></td> </tr> <tr> <td>\$30 Copay</td> <td>\$1000/3000 Annual Deductible</td> </tr> <tr> <td>\$0 Copay Children</td> <td>70% to \$3000/9000 OOP</td> </tr> <tr> <td>\$500 Hospital Copay</td> <td></td> </tr> </table>	<u>In Network</u>	<u>Out of Network</u>	\$30 Copay	\$1000/3000 Annual Deductible	\$0 Copay Children	70% to \$3000/9000 OOP	\$500 Hospital Copay										
<u>In Network</u>	<u>Out of Network</u>																	
\$30 Copay	\$1000/3000 Annual Deductible																	
\$0 Copay Children	70% to \$3000/9000 OOP																	
\$500 Hospital Copay																		
2	PPO 20/500 (2 tier available for existing enrollees only)	No Referral	\$0/25/40	National	1602.56	4652.61	1602.56	3846.13	2969.37	4813.84								
	<table border="0"> <tr> <td><u>In Network</u></td> <td><u>Out of Network</u></td> </tr> <tr> <td>\$20 Copay</td> <td>\$500/1500 Annual Deductible</td> </tr> <tr> <td>\$0 Copay Children</td> <td>80% to \$2000/6000 OOP</td> </tr> <tr> <td>No Hospital Copay</td> <td></td> </tr> </table>	<u>In Network</u>	<u>Out of Network</u>	\$20 Copay	\$500/1500 Annual Deductible	\$0 Copay Children	80% to \$2000/6000 OOP	No Hospital Copay										
<u>In Network</u>	<u>Out of Network</u>																	
\$20 Copay	\$500/1500 Annual Deductible																	
\$0 Copay Children	80% to \$2000/6000 OOP																	
No Hospital Copay																		

Rates are subject to NYS Insurance Department approval.

NOTES:

EH plans with prescription retail maximums are no longer available and have been replaced with corresponding plans without retail maximums.

RENEWAL RATES (existing groups)

DATED: 10/31/11

Please visit our web site, www.LIAHealthAlliance.com, and read the benefit summaries before finalizing your selections.

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.	PESLT2253D	No Referral	\$15 (Generic Only)	SELECT PRIME	382.29	1128.88	382.29	907.21	734.41	1192.09
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	448.74	1327.17	448.74	1,066.70	862.01	1399.01
3*	EPO 30/50 1000B Select \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	56 PESLT2381	No Referral	\$50 Ded. \$20/30/50	SELECT PRIME	445.87	1318.61	445.87	1059.81	856.50	1390.08
4	EPO 25/1000 Select \$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	PESLT2051	No Referral	\$20/30/50	SELECT PRIME	481.14	1423.88	481.14	1144.46	924.23	1499.91
5	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 \$3,000/6,000 coin max.	PFSLT5026	No Referral	\$15/30/50	SELECT PRIME	720.23	2137.32	720.23	1718.26	1383.35	2244.40
6*	PPO 30/50 1000 Select In Network \$30 Copay, \$1000 ded. hospital based services 90% coin, \$1,000 coin max. Out of Network \$1000/2000 Deductible 70% to \$3,000/6,000 coin max.	57 PFSLT6186	No Referral	\$50 Ded. \$20/30/50	SELECT PRIME	637.90	1891.64	637.90	1520.66	1225.25	1988.05
7	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.	PFSLTB017	No Referral	Not Covered	SELECT PRIME			461.40	1097.04	886.30	1438.40
8*	PPO 30/50 2000A Select In Network \$30 PCP/\$50 Specialist Copay, \$2000 ded hospital based services 80% coin, \$3,500 coin max. Out of Network \$2500/5000 Deductible 70% coins to \$4,000/8,000 coins max.	62 PFSLTA038	No Referral	Not Covered	SELECT PRIME	501.98	1486.04	501.98	1194.45	964.25	1564.80
HMO PLANS											
9	HMO 25/40A \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	PHSTD4057	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	643.40	1787.56	643.40	1512.00	1235.53	2003.55

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NOTES:

- 1) HIP members may renew in their existing plan ONLY or in those plans available for new business *.
- 2) New members to HIP from existing groups (coming from Atlantis) may renew into plans available for new business *.
- 3) Existing HIP members who want to make changes on renewal may only change into plans available for new business *.