

RELEASE DATE: 9/27/11 FOR NOVEMBER



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										
	COPAY		Referral No Ref	RX	Net Work	EMPLOYEE ONLY	FAMILY	Monthly Two Tier Rates		Monthly Four Tier Rates	
							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 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

NOVEMBER

DATED: 9/27/11

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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
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 \$4,500/13,500 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 \$4,500/13,500 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 90% to \$500/1,500 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
RENEWAL RATES (continued)

4th QUARTER 2011
NOVEMBER

RATE SHEET PLAN #	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
NON COST SHARING											
11	EPO 40/1000		No Referral								
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay		\$0 Generic Brand \$30, Non Pref \$50	National	588.26	1711.09	588.26	1411.79	1092.92	1770.91
12	EPO 40/1000A		No Referral								
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay		\$15 GENERIC ONLY	National	454.28	1320.37	454.28	1087.31	845.89	1368.31
13	EPO 40/1000B		No Referral								
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay		\$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		No Referral								
	\$40 Copay \$0 Copay Children \$100 ER	\$1000 Hospital Copay \$750 Ambulatory		\$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		No Referral								
	<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 \$8,000/24,000 OOP 70th percentile UCR		\$10 Generic, \$50 ded Brand \$25, Non Pref \$50	National	853.15	2479.26	853.15	2047.56	1582.96	2650.77
16	EPO 30/1000		No Referral								
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay		\$0 Generic Brand \$30, Non Pref \$50	National	630.97	1834.91	630.97	1514.28	1171.92	1899.03
17	EPO 30/500		No Referral								
	\$30 Copay \$0 Copay Children	\$500 Hospital Copay		\$0 Generic Brand \$30, Non Pref \$50	National	683.45	1987.11	683.45	1640.22	1268.98	2056.45

RATE SHEET	EMBLEM HEALTH										
	PLAN #		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- COMPREHEALTH											
18*	HMO-30/50/1000 \$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	301.71	881.8	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	3043.3	1047.66	2514.35	1942.78	3149.07	
	<u>In Network</u> \$30 Copay \$0 Copay Children \$500 Hospital Copay		<u>Out of Network</u> \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP								
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	
	<u>In Network</u> \$20 Copay \$0 Copay Children No Hospital Copay		<u>Out of Network</u> \$500/1500 Annual Deductible 80% to \$2000/6000 OOP								

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: 9/27/11

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 \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	PESLT2253D	No Referral	\$15 (Generic Only)	SELECT PRIME	#####	1128.9	#####	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	#####	1327.2	#####	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.		No Referral	\$50 Ded. \$20/30/50	SELECT PRIME	#####	1318.6	#####	1059.81	856.49	1390.07
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	#####	1423.88	#####	1144.46	924.23	1499.91
5	PPO 15/1000 Select <u>In Network</u> \$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max. <u>Out of Network</u> \$1000/2000 Deductible 80% to \$3000/6000 coin max.	PFSLT5026	No Referral	\$15/30/50	SELECT PRIME	#####	2137.32	#####	1718.26	#####	2244.40
6	PPO 30/50 2000 Select <u>In Network</u> \$30 PCP/\$50 Specialist Copay, \$2000 ded hospital based services 80% coin, \$5,000 coin max. <u>Out of Network</u> \$4000/8000 Deductible 60% coins to \$10,000/20,000 coins max.	PFSLTB017	No Referral	Not Covered	SELECT PRIME			#####	1097.04	886.30	1438.40
HMO PLANS											
7	HMO 25/40A \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	PHSTD4057	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	#####	1787.56	#####	1512.00	#####	2003.55

Rates are subject to NYS Insurance Department Approval

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 *.