

RELEASE DATE: 8/25/11 FOR OCTOBER



TRADITIONAL

4th QUARTER 2011

RENEWAL RATES

DATED: 8/22/11

Please visit our web site, [www.LIAHealthAlliance.com](http://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	
<b>HMO PLANS</b>											
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	
<b>POS PLANS</b>											
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  
OCTOBER

DATED: 8/24/11

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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 #	COST SHARING				Monthly Two Tier Rates			Monthly Four Tier Rates			
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* (Available for existing enrollees only)		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									

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
<b>NON COST SHARING</b>										
11	<b>EPO 40/1000</b> \$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	<b>EPO 40/1000A</b> \$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	<b>EPO 40/1000B</b> \$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	<b>EPO 40/1000/750</b> \$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	<b>PPO 40/500/5000</b> <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	No Referral	\$10 Generic, \$50 ded Brand \$25, Non Pref \$50	National	853.15	2479.26	853.15	2047.56	1582.96	2650.77
16	<b>EPO 30/1000</b> \$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	<b>EPO 30/500*</b> (Available for existing enrollees) \$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
18	<b>EPO 20*</b> (Available for existing enrollees only) \$20 Copay \$0 Copay Children \$0 Hospital Copay	No Referral	\$0/30/50	National	907.60	2637.1	907.60	2178.16	1683.66	2728.87



TRADITIONAL  
RENEWAL RATES (continued)

4th QUARTER 2011  
OCTOBER

RATE SHEET	EMBLEM HEALTH											
	COPAY		Referral No Ref	RX	NET WORK	Monthly Two Tier Rates		Monthly Four Tier Rates				
PLAN #					EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY		
<b>HMO- COMPREHEALTH</b>												
19	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
20	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
21	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
22	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
23	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.

\*THESE BENEFIT PLANS ARE ONLY AVAILABLE FOR GROUPS WHO CURRENTLY HAVE EMPLOYEES ENROLLED IN THEM.

TRADITIONAL  
RENEWAL RATES (existing groups)

4th QUARTER 2011

DATED: 8/24/11

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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	
<b>NON COST SHARING</b>											
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: 8/24/11

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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
<b>COST SHARING</b>											
1	<b>EPO 30/50 1000A Select</b> PESLT2253D	\$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	1192.09
2	<b>EPO 30/50 1000 Select</b> PESLT2254	\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	No Referral	\$20/30/50	SELECT PRIME	448.74	1327.17	448.74	1,066.70	862.01	1399.01
3	<b>EPO 25/1000 Select</b> PESLT2051	\$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	481.14	1423.88	481.14	1144.46	924.23	1499.91
4	<b>EPO 15/1000 Select</b> PESLT2053	\$15 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	501.63	1485.02	501.63	1193.64	963.58	1563.69
5*	<b>PPO 15/1000 Select</b> PFSLT5026	<b>In Network</b> \$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max. <b>Out of Network</b> \$1000/2000 Deductible 80% to \$3000/6000 coin max.	No Referral	\$15/30/50	SELECT PRIME	720.23	2137.32	720.23	1718.26	1383.35	2244.40
6	<b>PPO 30/50 2000 Select**</b> PFSLTB017	<b>In Network</b> \$30 PCP/\$50 Specialist Copay, \$2000 ded hospital based services 80% coin, \$5,000 coin max. <b>Out of Network</b> \$4000/8000 Deductible 60% coins to \$10,000/20,000 coins max.	No Referral	Not Covered	SELECT PRIME			461.40	1097.04	886.30	1438.40
<b>HMO PLANS</b>											
7*	<b>HMO 25/40A</b> PHSTD4057	\$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	643.40	1787.56	643.40	1512.00	1235.53	2003.55

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- \* THE 2 PLANS ABOVE WITH AN \* ARE ONLY AVAILABLE FOR GROUPS WHO CURRENTLY HAVE EMPLOYEES ENROLLED IN
- \*\* Replacement plan for SmartStart enrollees.
- \*\*\* Existing accounts who wish to change plan options will only be allowed to change into plan options available for new sales w are Plans 1,2,3,5,& 6 unless you choose a different insurer.