

RELEASE DATE: 11/23/09



TRADITIONAL
RENEWAL RATES

1st QUARTER 2010

DATED: 12/29/09 (11/9/09)

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	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 Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	342.36	878.15	342.36	684.72	688.49	1053.78
2	HMO 20A \$20 Copay \$500 Hospital Copay		No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	357.97	918.19	357.97	715.94	719.88	1101.83
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay		No Referral	\$0/30/50	Atlantis	373.30	957.51	373.30	746.60	750.71	1149.02
4	HMO 20 \$20 Copay \$500 Hospital Copay		No Referral	\$20/30/40	Atlantis	382.16	980.24	382.16	764.32	768.52	1176.29
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay		No Referral	\$0/30/50	Atlantis	425.34	1091.00	425.34	850.68	855.36	1309.20
6	HMO 20 Plus \$20 Copay No Hospital Copay		No Referral	\$20/30/40	Atlantis	437.44	1122.03	437.44	874.88	879.69	1346.44
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 Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	391.90	1005.22	391.90	783.80	788.11	1206.27
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 Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	405.43	1039.93	405.43	810.86	815.32	1247.91
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	416.09	1067.27	416.09	832.18	836.76	1280.73
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	513.55	1317.26	513.55	1027.10	1032.75	1580.71
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	488.66	1253.41	488.66	977.32	982.70	1504.10
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	563.16	1444.51	563.16	1126.32	1132.51	1733.41

**TRADITIONAL
RENEWAL RATES**

1st QUARTER 2010

DATED: 11/9/09

RATE SHEET PLAN #	ATLANTIS Signature									
	COPAY	Referral No Ref	RX	Net Work	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
Signature HMO PLANS										
13	HMO 30/50/1000* \$30 PCP / \$50 Specialist Copay \$1000 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	271.73	696.99	271.73	543.46	546.45	836.38
14	HMO 30/50/750* \$30 PCP / \$50 Specialist Copay \$750 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	275.23	705.96	275.23	550.46	553.49	825.69
15	HMO 25/40/1000* \$25 PCP / \$40 Specialist Copay \$1000 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	276.73	709.81	276.73	553.46	556.50	851.77
16	HMO 0/50/1000* \$0 PCP / \$50 Specialist Copay \$1000 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	281.73	722.64	281.73	563.46	566.56	867.16
17	HMO 0/30/500* \$0 PCP / \$30 Specialist Copay \$500 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis Signature	325.73	835.50	325.73	651.46	655.04	1002.60
18	HMO 30/50/1000A* \$30 PCP / \$50 Specialist Copay \$1000 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	302.67	776.35	302.67	605.34	608.67	931.62
19	HMO 30/50/750A* \$30 PCP / \$50 Specialist Copay \$750 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	306.17	785.33	306.17	612.34	615.71	918.51
20	HMO 25/40/1000A* \$25 PCP / \$40 Specialist Copay \$1000 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	307.67	789.17	307.67	615.34	618.72	947.01
21	HMO 0/50/1000A* \$0 PCP / \$50 Specialist Copay \$1000 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	312.67	802.00	312.67	625.34	628.78	962.40
22	HMO 0/30/500A* \$0 PCP / \$30 Specialist Copay \$500 Hospital Copay	No Referral	\$0/\$30/\$50	Atlantis Signature	356.67	914.86	356.67	713.34	717.26	1097.83

*Plans and rates above have not met final approval of the NY Department of Insurance. Benefits and Rates are subject to change without notice.

**TRADITIONAL
RENEWAL RATES**

1st QUARTER 2010

DATED: 1/4/10 (11/19/09)

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

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	
COST SHARING											
1	CS EPO 40/1000A \$40 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	None	National	294.97	756.26	294.97	648.85	563.87	874.74	
2	CS EPO 40/2000 \$40 Copay \$0 Copay Children \$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	318.68	816.81	318.68	701.11	608.96	944.8	
3	CS EPO 40/1000 \$40 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	362.5	928.47	362.5	797.43	692.18	1073.98	
4	CS EPO 30/1000 \$30 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	377.61	967.02	377.61	830.68	720.90	1118.58	
5	CS EPO 30/500 \$30 Copay \$0 Copay Children \$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	417.96	1069.84	417.96	919.40	797.52	1237.53	
6	CS PPO 40/2000 <u>In Network</u> \$40 Copay - Annual Ded for hospital based services \$1000/3000 80% to \$3000/9000 OOP \$0 Copay Children <u>Out of Network</u> \$2000/6000 Annual Deductible 60% to \$6,000/18,000 OOP	No Referral	\$0/25/50 Annual Retail Max \$750 Mail Order Unlimited	National	516.08	1320.14	516.08	1135.53	983.98	1,527.09	
7	CS PPO 40/2000A <u>In Network</u> \$40 Copay - Annual Ded for hospital based services \$1000/3000 80% to \$3000/9000 OOP \$0 Copay Children <u>Out of Network</u> \$2000/6000 Annual Deductible 60% to \$6,000/18,000 OOP	No Referral	\$0/25/50 Annual Retail Max \$3,000 Mail Order Unlimited	National	545.19	1394.37	545.19	1199.36	1039.29	1612.94	
NON COST SHARING											
8	EPO 40/1000 \$40 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited	National	400.38	1025.09	400.38	880.78	764.15	1185.77	
9	EPO 30/1000A \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	432.74	1107.59	432.74	951.94	825.64	1281.2	
10	EPO 30/1000 \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	453.34	1160.08	453.34	997.23	864.77	1341.92	
11	EPO 30/500 \$30 Copay \$0 Copay Children \$500 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	485.53	1242.17	485.53	1068.07	925.90	1436.87	

TRADITIONAL
RENEWAL RATES (continued)

1st QUARTER 2010

RATE SHEET	EMBLEM HEALTH														
	COPAY			Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	Monthly Two Tier Rates			Monthly Four Tier Rates			
PLAN #								EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY				
NON COST SHARING (continued)															
12	EPO 20A														
	\$20 Copay	\$0 Hospital Copay	No	\$0 Generic	National	616.96	1577.25	616.96	1357.2	1175.6	1824.55				
	\$0 Copay Children		Referral	\$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited											
13	EPO 20														
	\$20 Copay	\$0 Hospital Copay	No	\$0/30/50	National	644.20	1646.72	644.2	1417.14	1227.35	1904.91				
	\$0 Copay Children		Referral												
14	PPO 25/1000														
	<u>In Network</u>	<u>Out of Network</u>	No	\$0/25/40	National	905.57	2313.28	905.57	1992.09	1723.98	2675.96				
	\$25 Copay	\$1000/3000 Annual Deductible	Referral												
	\$0 Copay Children	70% to \$3000/9000 OOP													
	\$500 Hospital Copay														
15	PPO 30/1000														
	<u>In Network</u>	<u>Out of Network</u>	No	\$0 Generic	National	638.87	1633.23	638.87	1405.45	1217.27	1889.26				
	\$30 Copay	\$1000/3000 Annual Deductible	Referral	\$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited											
	\$0 Copay Children	70% to \$3000/9000 OOP													
	\$500 Hospital Copay														
16	PPO 30/1000A														
	<u>In Network</u>	<u>Out of Network</u>	No	\$0 Generic	National	662.07	1692.41	662.07	1456.49	1261.36	1957.71				
	\$30 Copay	\$1000/3000 Annual Deductible	Referral	\$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$3000 Mail Order Unlimited											
	\$0 Copay Children	70% to \$3000/9000 OOP													
	\$500 Hospital Copay														
HMO- COMPREHEALTH															
17	HMO-30/50/1000														
	\$30 PCP / \$50 Specialist Copay	\$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	273.30	699.67	273.30	601.26	522.00	808.97				
	\$0 Copay Children														
18	HMO-30/50/500														
	\$30 PCP / \$50 Specialist Copay	\$500 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	291.99	747.81	291.99	642.38	557.70	864.29				
	\$0 Copay Children														
19	HMO-25/40/500A														
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay	Referral	\$25 Generic/\$35 Brand	Comprehealth	329.96	845.00	329.96	725.93	630.24	976.69				
	\$0 Copay Children														
20	HMO-25/40/500														
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay	Referral	\$0 Generic \$30 Brand	Comprehealth	396.29	1014.80	396.29	871.89	756.97	1173.07				
	\$0 Copay Children														
21	HMO-20/25/200														
	\$20 PCP / \$25 Specialist Copay	\$200 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	347.70	890.13	347.70	764.93	664.11	1029.20				
	\$0 Copay Children														

Rates are subject to NYS Insurance Department approval.

NOTES:

EH PPO requires 50% participation in EH products (class carve-outs allowed).
All EH prescriptions are Voluntary Home Delivery and are NO LONGER mandatory generic.
NY Metro is a limited network.

TRADITIONAL
RENEWAL RATES (existing groups)

1st QUARTER 2010

DATED: 11/19/09

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)
COST SHARING											
1	CS EPO 40/1000A \$40 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP		No Referral	None	National	294.97	756.26	294.97	648.85	563.87	874.74
2	CS EPO 40/2000 \$40 Copay \$0 Copay Children \$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	318.68	816.81	318.68	701.11	608.96	944.80
3	CS EPO 40/1000 \$40 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	362.50	928.47	362.50	797.43	692.18	1073.98
4	CS EPO 30/1000 \$30 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	377.61	967.02	377.61	830.68	720.90	1118.58
5	CS EPO 30/500 \$30 Copay \$0 Copay Children \$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	417.96	1069.84	417.96	919.40	797.52	1,237.53
6	CS PPO 30/2000 <u>In Network</u> \$30 Copay - Annual Ded for hospital based services \$1000/3000 90% to \$500/1500 OOP \$0 Copay Children <u>Out of Network</u> \$2000/6000 Annual Deductible 70% to \$1500/4500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	590.96	1511.03	590.96	1300.07	1126.25	1747.96
7	CS PPO 30/2000A <u>In Network</u> \$30 Copay - Annual Ded for hospital based services \$1000/3000 90% to \$500/1500 OOP \$0 Copay Children <u>Out of Network</u> \$2000/6000 Annual Deductible 70% to \$1500/4500 OOP		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	611.56	1563.52	611.56	1345.36	1165.38	1808.68

RENEWAL RATES- (existing groups continued)

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											
8	EPO 40/1000 \$40 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited	National	400.38	1025.09	400.38	880.78	764.15	1185.77	
9	EPO 30/1000A \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	432.74	1107.59	432.74	951.94	825.64	1281.20	
10	EPO 30/1000 \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	453.34	1160.08	453.34	997.23	864.77	1341.92	
11	EPO 30/500 \$30 Copay \$0 Copay Children \$500 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	485.53	1242.17	485.53	1068.07	925.90	1436.87	
12	EPO 20A \$20 Copay \$0 Copay Children \$0 Hospital Copay	No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	619.96	1577.25	619.96	1357.20	1175.60	1824.55	
13	EPO 20 \$20 Copay \$0 Copay Children \$0 Hospital Copay	No Referral	\$0/30/50	National	644.20	1646.72	644.20	1417.14	1227.35	1904.91	
14	PPO 25/1000 <u>In Network</u> \$25 Copay \$0 Copay Children \$500 Hospital Copay <u>Out of Network</u> \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP	No Referral	\$0/25/40	National	905.57	2313.28	905.57	1992.09	1723.98	2675.96	
15	PPO 30/1000 <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	No Referral	\$0 Generic \$50 Ded, Brand \$25, Non Pref \$40 Annual Retail Max \$3,000 Mail Order Unlimited	National	766.72	1959.21	766.72	1686.63	1460.18	2266.32	
16	PPO 20/500 <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	No Referral	\$0/25/40	National	1130.61	2887.12	1130.61	2487.25	2151.6	3339.94	

Rates are subject to NYS Insurance Department approval.

NOTES:

GHI PPO requires 50% participation in GHI products (class carve-outs allowed).

All GHI prescriptions are Voluntary Home Delivery and are NO LONGER mandatory generic.

TRADITIONAL
RENEWAL RATES (existing groups)

DATED: 11/23/09

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	EMPLOYEE ONLY	FAMILY	Monthly Two Tier Rates			Monthly Three Tier Rates			Monthly Four Tier Rates		
								EMPLOYEE ONLY	EMPLOYEE + ONE	FAMILY	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(ren)	FAMILY		
COST SHARING																
1	EPO 25 SMART START (Limited Hospital Based Network)	\$25 Copay Hospital Copay \$250 1st two days, then \$100 per day, Max \$1400 per stay Annual Benefit Max \$100,000 per individual Lifetime Max \$500,000 per individual	No Referral	NONE	SmartStart						349.83	734.64	944.54			
2	EPO 30/50 1000A Select	\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	No Referral	\$15 (Generic Only)	SELECT PRIME	312.74	807.13	312.74	602.86	958.67	312.74	625.57	581.78	957.15		
3	EPO 30/50 1000 Select	\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$1000 coin max.	No Referral	\$20/30/50	SELECT PRIME	364.31	933.49	364.31	697.04	1108.61	364.31	728.72	677.71	1114.92		
4	EPO 25/1000 Select	\$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	390.19	997.04	390.19	744.49	1184.07	390.19	780.37	725.73	1193.93		
5	EPO 15/1000 Select	\$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	406.41	1036.79	406.41	774.20	1231.29	406.41	812.83	755.92	1243.59		
6*	PPO 15/1000 Select	In Network \$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	No Referral	\$15/30/50	SELECT PRIME	576.21	1473.16	576.21	1100.12	1749.56	576.21	1152.42	1071.72	1763.14		
		Out of Network \$1000/2000 Deductible 80% to \$3000/6000 coin max.														
7*	PPO 30/50 1000 Select	In Network PCP \$30 / \$50 Specialist Copay, \$1000 ded hospital based services 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	521.93	1340.18	521.93	1000.80	1591.64	521.93	1043.86	970.76	1597.05		
		Out of Network \$1000/2000 Ded. 80% to \$3000/6000 coin max.														
8*	PPO 25/1000 Select	In Network \$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	549.90	1408.71	549.90	1051.98	1673.03	549.90	1099.79	1022.78	1682.63		
		Out of Network \$1000/2000 Deductible 80% to \$3000/6000														
HMO PLANS																
9*	HMO SUPER VALUE	\$20 Copay \$500 Hospital Copay	Referral	\$100 Deductible \$10 (Generic Only) Name Brand Discount	PRIME	523.95	1350.95	523.95	1009.00	1604.55	523.95	1047.89	974.53	1603.26		
10*	HMO 25/40A	\$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	549.79	1414.28	549.79	1056.17	1679.65	549.79	1099.59	1022.63	1682.32		
11*	HMO VALUE	\$20 Copay \$500 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	585.37	1501.42	585.37	1121.15	1783.09	585.37	1170.71	1088.77	1791.13		
12*	HMO 20	\$20 Copay \$250 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	602.81	1544.14	602.81	1153.08	1833.86	602.81	1205.60	1121.20	1844.50		
13*	HMO 5	\$5 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	629.67	1609.98	629.67	1202.23	1912.01	629.67	1259.34	1171.17	1926.70		
14*	HMO 15	\$15 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	617.23	1579.47	617.23	1179.47	1875.80	617.23	1234.45	1148.02	1888.63		
15*	HMO 10	\$10 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	624.87	1598.18	624.87	1193.45	1898.03	624.87	1249.72	1162.23	1912.00		
POS PLANS																
16	POS 20/1000	In Network \$20 Copay \$250 Hospital Copay	Referral	\$7/30/50	PRIME	716.87	1,858.50	716.87	1387.88	2207.21	716.87	1433.73	1333.36	2193.50		
		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 HIP.

**TRADITIONAL
RENEWAL RATES (existing groups)**

DATED: 11/23/09

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

RATE SHEET	HIP Plans with VYTRA Premium Network													
	Monthly Two Tier Rates				Monthly Three Tier Rates				Monthly Four Tier Rates					
PLAN #	COPAY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE + ONE	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY	
HMO PLANS														
DIRECT ACCESS HMO PLANS														
1	HMO 20 \$20 Copay \$250 Hospital Copay	No Referral	\$10/20/50	Vytra Premium	693.02	1773.13	693.02	1323.99	2105.71	693.02	1386.03	1289.01	2120.52	
2	HMO 15 \$15 Copay \$250 Hospital Copay	No Referral	\$10/20/50	Vytra Premium	703.35	1798.42	703.35	1342.89	2135.76	703.35	1406.69	1308.19	2152.11	
3	HMO 10 \$10 Copay No Hospital Copay	No Referral	\$10/20/50	Vytra Premium	715.60	1828.46	715.60	1365.30	2171.41	715.60	1431.20	1331.00	2189.61	
POS PLANS														
4	POS 20/1000 In Network \$20 Copay Hospital Copay \$250 Out of Network \$1000/2000 Deductible 70% to \$2000/\$4000 OOP	Referral	\$10/20/40 Covered only at participating pharmacies	Vytra Premium	773.89	2002.50	773.89	1495.33	2378.18	773.89	1547.78	1439.43	2367.99	
5	POS 15/500 In Network \$15 Copay No Hospital Copay Out of Network \$500/1000 Deductible 70% to \$2000/\$4000 OOP	Referral	\$7/15/35 Covered only at participating pharmacies	Vytra Premium	847.18	2182.05	847.18	1629.37	2591.38	847.18	1694.35	1575.74	2592.21	
6	POS 10/250 In Network \$10 Copay No Hospital Copay Out of Network \$250/500 Deductible 80% to \$1000/\$2000 OOP	Referral	\$5/10/35 Covered only at participating pharmacies	Vytra Premium	977.24	2512.02	977.24	1875.73	2983.26	977.24	1954.46	1817.67	2990.21	

Rates are subject to NYS Insurance Department Approval

The PPO Plans utilize the PHCS network providers ONLY OUTSIDE the 10 county service area which includes: Nassau, Suffolk, Brooklyn, Bronx, Queens, Manhattan, Staten Island, Westchester, Rockland and Orange counties.

THESE BENEFIT PLANS ARE ONLY AVAILABLE FOR GROUPS WHO CURRENTLY HAVE EMPLOYEES ENROLLED IN HIP.