

RELEASE DATE: 3/10/10



TRADITIONAL
RENEWAL RATES

2nd QUARTER 2010

DATED: 2/12/10

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	350.92	900.11	350.92	701.84	705.70	1080.13
2	HMO 20A \$20 Copay \$500 Hospital Copay		No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	366.92	941.15	366.92	733.84	737.88	1129.38
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay		No Referral	\$0/30/50	Atlantis	382.63	981.45	382.63	765.26	769.47	1177.74
4	HMO 20 \$20 Copay \$500 Hospital Copay		No Referral	\$20/30/40	Atlantis	391.72	1004.76	391.72	783.44	787.75	1205.71
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay		No Referral	\$0/30/50	Atlantis	435.97	1118.26	435.97	871.94	876.74	1341.92
6	HMO 20 Plus \$20 Copay No Hospital Copay		No Referral	\$20/30/40	Atlantis	448.38	1150.09	448.38	896.76	901.69	1380.11
POS PLANS											
7	POS 25/40 2000A In Network \$25 PCP/\$40 Spec Copay \$500 Hospital Copay		No Referral	Out of Network \$2000/4000 Deductible 70% to \$5,000/\$10,000 Max OOP \$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	403.56	1035.13	403.56	807.12	811.56	1242.16
8	POS 20/2000 In Network \$20 Copay \$500 Hospital Copay		No Referral	Out of Network \$2000/4000 Deductible 70% to \$5,000/\$10,000 Max OOP \$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	417.49	1070.86	417.49	834.98	839.57	1285.03
9	POS 25/40 2000 In Network \$25 PCP/\$40 Spec Copay \$500 Hospital Copay		No Referral	\$20/30/40 Out of Network \$2000/4000 Deductible 70% to \$5,000/\$10,000 Max OOP	Atlantis	428.36	1098.74	428.36	856.72	861.43	1318.49
10	POS 20/1000 In Network \$20 Copay \$0 Hospital Copay		No Referral	\$0/30/50 Out of Network \$1000/2500 Deductible 70% to \$3,000/\$7,500 Max OOP	Atlantis	528.70	1356.12	528.70	1057.40	1063.22	1627.34
11	POS 25/40 1000 Plus In Network \$25 PCP/\$40 Spec Copay \$0 Hospital Copay		No Referral	\$0/\$30/\$50 Out of Network \$1000/2500 Deductible 70% to \$3,000/\$7,500 Max OOP	Atlantis	503.06	1290.35	503.06	1006.12	1011.65	1548.42
12	POS 20/500 In Network \$20 Copay \$0 Hospital Copay		No Referral	\$20/30/40 Out of Network \$500/1250 Deductible 70% to \$3,000/\$7,500 Max OOP	Atlantis	579.84	1487.29	579.84	1159.68	1166.06	1784.75

**TRADITIONAL
RENEWAL RATES**

2nd QUARTER 2010

REVISED: 3/10/10 (2/17/10)

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

RATE SHEET	Monthly									
	Two Tier Rates					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 40/1000A									
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	None	National	318.53	880.03	318.53	700.68	608.74 944.38
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	340.76	941.16	340.76	749.69	651.02 1010.08
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	388.09	1071.31	388.09	853.72	740.90 1149.60
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	404.40	1116.19	404.40	889.63	771.92 1197.77
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	446.94	1233.20	446.94	983.18	852.70 1,323.20
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 Generic \$50 Ded, Brand \$25, Non Pref \$50 Annual Retail Max \$750 Mail Order Unlimited	National	555.66	1532.17	555.66	1222.42	1059.30 1,644.02
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 Generic \$50 Ded, Brand \$25, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	586.40	1616.71	586.40	1290.04	1117.71 1,734.67
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	415.69	1147.23	415.69	914.46	793.35 1231.08
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	449.35	1239.78	449.35	988.47	857.30 1330.33
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	470.56	1298.13	470.56	1035.12	897.60 1392.87
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	511.92	1411.91	511.92	1126.15	976.17 1514.90

TRADITIONAL
RENEWAL RATES (continued)

2nd QUARTER 2010

RATE SHEET	EMBLEM HEALTH										
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
	NON COST SHARING (continued)										
12	EPO 20A (existing enrollees only)		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	677.54	1867.35	677.54	1490.49	1290.82	2003.42
	\$20 Copay	\$0 Hospital Copay									
	\$0 Copay Children										
13	EPO 20 (existing enrollees only)		No Referral	\$0/30/50	National	705.60	1944.51	705.60	1552.22	1344.13	2086.19
	\$20 Copay	\$0 Hospital Copay									
	\$0 Copay Children										
14	PPO 25/1000 (2 tier available for existing enrollees only)		No Referral	\$0/25/40	National	993.38	2735.89	993.38	2185.28	1890.94	2935.16
	In Network	Out of Network									
	\$25 Copay	\$1000/3000 Annual Deductible									
	\$0 Copay Children										
	\$500 Hospital Copay										
15	PPO 30/1000 (2 tier available for existing enrollees only)		No Referral	\$0 Generic \$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited	National	698.69	1925.5	698.69	1537.06	1331.05	2065.89
	In Network	Out of Network									
	\$30 Copay	\$1000/3000 Annual Deductible									
	\$0 Copay Children										
	\$500 Hospital Copay										
16	PPO 30/1000A (2 tier available for existing enrollees only)		No Referral	\$0 Generic \$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$3000 Mail Order Unlimited	National	723.19	1992.87	723.19	1590.96	1377.61	2138.17
	In Network	Out of Network									
	\$30 Copay	\$1000/3000 Annual Deductible									
	\$0 Copay Children										
	\$500 Hospital Copay										
	HMO- COMPREHEALTH										
17	HMO-30/50/1000		Referral	\$15 Generic Only	Comprehealth	273.44	700.01	273.44	601.56	522.25	809.36
	\$30 PCP / \$50 Specialist Copay	\$1000 Hospital Copay									
	\$0 Copay Children										
18	HMO-30/50/500		Referral	\$15 Generic Only	Comprehealth	292.13	747.85	292.13	642.68	557.95	864.68
	\$30 PCP / \$50 Specialist Copay	\$500 Hospital Copay									
	\$0 Copay Children										
19	HMO-25/40/500A		Referral	\$25 Generic/\$35 Brand	Comprehealth	330.46	845.97	330.46	727.02	631.18	978.16
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay									
	\$0 Copay Children										
20	HMO-25/40/500		Referral	\$0 Generic \$30 Brand	Comprehealth	398.46	1020.05	398.46	876.62	761.06	1179.44
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay									
	\$0 Copay Children										
21	HMO-20/25/200		Referral	\$15 Generic Only	Comprehealth	347.84	890.47	347.84	765.23	664.36	1029.59
	\$20 PCP / \$25 Specialist Copay	\$200 Hospital Copay									
	\$0 Copay Children										

Rates are subject to NYS Insurance Department approval.

NOTES:

- 1) All EH prescriptions are Voluntary Home Delivery and are NO LONGER mandatory generic.
- 2) NY Metro is a limited network.
- 3) Existing enrollees ONLY can renew into Plans (#12 EPO 20A and #13 EPO 20).
- 4) Non Cost Sharing PPO Plans (#14 PPO 25/1000, #15 PPO 30/1000 and #16 PPO 30/1000A) are no longer available with 2-Tier rates EXCEPT for existing enrollees.

RENEWAL RATES (existing groups)

REVISED: 3/9/10 (2/18/10)

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	
COST SHARING											
1	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	634.82	1749.85	634.82	1396.57	1209.69	1877.50
2	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	656.03	1808.20	656.03	1443.22	1249.99	1940.04
NON COST SHARING											
3	PPO 30/1000G (2 tier available for existing enrollees only) <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	834.04	2297.70	834.04	1834.73	1598.20	2457.06
4	PPO 20/500 (2 tier available for existing enrollees only) <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	1232.34	3393.05	1232.34	2711.15	2345.03	3640.29

Rates are subject to NYS Insurance Department approval.

NOTES:

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

TRADITIONAL
RENEWAL RATES (existing groups)

DATED: 2/5/10

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 Three Tier Rates			Monthly Four Tier Rates		
						EMPLOYEE ONLY	FAMILY	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			356.83	749.34	963.44				
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	320.27	826.43	320.27	617.27	981.58	320.27	640.66	595.80	980.21
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	373.14	955.96	373.14	713.8	1135.27	373.14	746.39	694.13	1141.93
4	EPO 25/1000 Select	\$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	399.07	1019.63	399.07	761.34	1210.87	399.07	798.13	742.24	1221.09
5	EPO 15/1000 Select	\$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	415.30	1059.37	415.30	791.05	1258.08	415.30	830.58	772.42	1270.75
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	588.39	1504.25	588.39	1123.31	1786.45	588.39	1176.78	1094.37	1800.41
		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	533.93	1370.81	533.93	1023.67	1628.00	533.93	1067.85	993.07	1633.74
		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	561.90	1439.34	561.90	1074.84	1709.38	561.90	1123.78	1045.09	1719.33
		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	535.29	1380.09	535.29	1030.18	1639.17	535.29	1070.58	995.63	1637.98
10*	HMO 25/40A	\$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	562.19	1445.99	562.19	1079.85	1717.31	562.19	1124.37	1045.66	1720.23
11*	HMO VALUE	\$20 Copay \$500 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	598.23	1534.30	598.23	1145.70	1822.14	598.23	1196.46	1112.70	1830.51
12*	HMO 20	\$20 Copay \$250 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	615.68	1577.02	615.68	1177.63	1872.90	615.68	1231.34	1145.13	1883.88
13*	HMO 5	\$5 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	642.59	1642.99	642.59	1226.88	1951.21	642.59	1285.18	1195.19	1966.23
14*	HMO 15	\$15 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	630.15	1612.48	630.15	1204.11	1915.00	630.15	1260.29	1172.04	1928.16
15*	HMO 10	\$10 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	637.78	1631.19	637.78	1218.09	1937.23	637.78	1275.56	1186.26	1951.53
POS PLANS														
16	POS 20/1000	In Network \$20 Copay \$250 Hospital Copay	Referral	\$7/30/50	PRIME	735.48	1,906.16	735.48	1423.46	2263.80	735.48	1470.95	1368.00	2250.47
		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: 2/11/10

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

RATE SHEET	Monthly													
	Two Tier Rates				Three Tier Rates			Four Tier Rates						
PLAN #	HIP Plans with VYTRA Premium Network													
	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	707.98	1811.30	707.98	1352.48	2151.04	707.98	1415.96	1316.83	2166.30	
2	HMO 15 \$15 Copay \$250 Hospital Copay	No Referral	\$10/20/50	Vytra Premium	718.31	1836.59	718.31	1371.38	2181.09	718.31	1436.61	1336.02	2197.89	
3	HMO 10 \$10 Copay No Hospital Copay	No Referral	\$10/20/50	Vytra Premium	730.57	1866.62	730.57	1393.79	2216.74	730.57	1461.12	1358.83	2235.39	
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	793.93	2053.73	793.93	1533.57	2439.01	793.93	1587.85	1476.70	2429.31	
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	867.71	2234.47	867.71	1668.50	2653.61	867.71	1735.40	1613.92	2655.02	
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	1000.04	2570.23	1000.04	1919.20	3052.40	1000.04	2000.06	1860.07	3059.96	

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.