

RELEASE DATE: 5/17/10



TRADITIONAL  
RENEWAL RATES

3rd QUARTER 2010

DATED: 5/14/10

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	EMPLOYEE ONLY		EMPLOYEE +SPOUSE +CHILD(ren)
	Monthly Two Tier Rates					Monthly Four Tier Rates				
<b>HMO PLANS</b>										
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	359.69	922.60	359.69	719.38	723.34	1107.13
2	HMO 20A \$20 Copay \$500 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	376.09	964.67	376.09	752.18	756.32	1157.61
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0/30/50	Atlantis	392.19	1005.97	392.19	784.38	788.69	1207.16
4	HMO 20 \$20 Copay \$500 Hospital Copay	No Referral	\$20/30/40	Atlantis	401.51	1029.87	401.51	803.02	807.44	1235.85
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay	No Referral	\$0/30/50	Atlantis	446.87	1146.22	446.87	893.74	898.66	1375.47
6	HMO 20 Plus \$20 Copay No Hospital Copay	No Referral	\$20/30/40	Atlantis	459.59	1178.85	459.59	919.18	924.24	1414.62
<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 Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	TBA	TBA	TBA	TBA	TBA	TBA
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	TBA	TBA	TBA	TBA	TBA	TBA
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	TBA	TBA	TBA	TBA	TBA	TBA
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	TBA	TBA	TBA	TBA	TBA	TBA
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	TBA	TBA	TBA	TBA	TBA	TBA
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	TBA	TBA	TBA	TBA	TBA	TBA

Rates are subject to NYS Insurance Department Approval

NOTE: Atlantis POS plans are only available for Renewals only.

**TRADITIONAL  
RENEWAL RATES**

**3rd QUARTER 2010**

DATED: 5/17/10

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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)
PLAN #	EMBLEM HEALTH										
<b>COST SHARING</b>											
1	<b>CS EPO 40/1000A</b>		No Referral	None	National	325.13	947.09	325.13	780.34	605.29	980.39
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
2	<b>CS EPO 40/2000</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	348.09	1013.66	348.09	835.43	647.77	1049.28
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP									
3	<b>CS EPO 40/1000</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	396.40	1153.76	396.40	951.38	737.14	1194.19
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
4	<b>CS EPO 30/1000</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	413.05	1202.03	413.05	991.33	767.93	1244.14
	\$30 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
5	<b>CS EPO 30/500</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	456.55	1328.18	456.55	1095.73	848.40	1374.65
	\$30 Copay \$0 Copay Children	\$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP									
6	<b>CS PPO 40/2000</b>		No Referral	\$0 Generic \$50 Ded, Brand \$25, Non Pref \$50 Annual Retail Max \$750 Mail Order Unlimited	National	574.45	1670.13	574.45	1378.71	1066.54	1728.36
	<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									
7	<b>CS PPO 40/2000A</b>		No Referral	\$0 Generic \$50 Ded, Brand \$25, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	605.95	1761.45	605.95	1454.29	1124.81	1822.84
	<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									
<b>NON COST SHARING</b>											
8	<b>EPO 40/1000</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited	National	426.24	1240.31	426.24	1022.98	792.35	1283.72
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
9	<b>EPO 30/1000A</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	460.76	1340.40	460.76	1105.83	856.20	1387.28
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay									
10	<b>EPO 30/1000</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	482.49	1403.42	482.49	1157.99	896.39	1452.48
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay									
11	<b>EPO 30/500</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	524.91	1526.43	524.91	1259.79	974.85	1579.72
	\$30 Copay \$0 Copay Children	\$500 Hospital Copay									

**TRADITIONAL  
RENEWAL RATES (continued)**

**3rd QUARTER 2010**

RATE SHEET	EMBLEM HEALTH										
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
	<b>NON COST SHARING (continued)</b>										
12	<b>EPO 20A (existing enrollees only)</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	706.08	2051.82	706.08	1694.60	1310.02	2123.23
	\$20 Copay \$0 Copay Children	\$0 Hospital Copay									
13	<b>EPO 20 (existing enrollees only)</b>		No Referral	\$0/30/50	National	734.83	2135.19	734.83	1763.58	1363.21	2209.47
	\$20 Copay \$0 Copay Children	\$0 Hospital Copay									
14	<b>PPO 25/1000 (2 tier available for existing enrollees only)</b>		No Referral	\$0/25/40	National	1036.00	3008.60	1036.00	2486.41	1920.38	3113.00
	<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									
15	<b>PPO 30/1000 (2 tier available for existing enrollees only)</b>		No Referral	\$0 Generic \$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$1000 Mail Order Unlimited	National	728.42	2116.60	728.42	1748.19	1351.35	2190.22
	<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									
16	<b>PPO 30/1000A (2 tier available for existing enrollees only)</b>		No Referral	\$0 Generic \$50 Ded, Brand 25, Non Pref \$50 Annual Retail Max \$3000 Mail Order Unlimited	National	753.52	2189.39	753.52	1808.44	1397.79	2265.52
	<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									
	<b>HMO- COMPREHEALTH</b>										
17	<b>HMO-30/50/1000</b>		Referral	\$15 Generic Only	Comprehealth	260.37	755.08	260.37	624.88	481.68	781.12
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay									
18	<b>HMO-30/50/500</b>		Referral	\$15 Generic Only	Comprehealth	290.20	841.58	290.20	696.45	536.86	870.61
	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
19	<b>HMO-25/40/500A</b>		Referral	\$25 Generic/\$35 Brand	Comprehealth	330.17	957.50	330.17	792.41	610.80	990.51
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
20	<b>HMO-25/40/500</b>		Referral	\$0 Generic \$30 Brand	Comprehealth	399.87	1159.61	399.87	959.67	739.54	1199.55
	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay									
21	<b>HMO-20/25/200</b>		Referral	\$15 Generic Only	Comprehealth	352.27	1021.55	352.27	845.45	659.69	1056.82
	\$20 PCP / \$25 Specialist Copay \$0 Copay Children	\$200 Hospital Copay									

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.

TRADITIONAL  
**RENEWAL RATES (existing groups)**

3rd QUARTER 2010

DATED: 5/12/10

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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)
<b>COST SHARING</b>											
1	<b>CS PPO 30/2000</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$1,000 Mail Order Unlimited	National	656.44	1907.87	656.44	1575.47	1218.21	1974.32
	<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									
2	<b>CS PPO 30/2000A</b>		No Referral	\$0 Generic \$50 Ded, Brand \$30, Non Pref \$50 Annual Retail Max \$3,000 Mail Order Unlimited	National	678.17	1970.89	678.17	1627.63	1258.40	2039.52
	<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									
<b>NON COST SHARING</b>											
3	<b>PPO 30/1000G (2 tier available for existing enrollees only)</b>		No Referral	\$0 Generic \$50 Ded, Brand \$25, Non Pref \$40 Annual Retail Max \$3,000 Mail Order Unlimited	National	869.88	2526.84	868.88	2087.72	1613.06	2522.89
	<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									
4	<b>PPO 20/500 (2 tier available for existing enrollees only)</b>		No Referral	\$0/25/40	National	1297.25	3766.23	1297.25	3113.40	2403.68	3896.74
	<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:**

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

TRADITIONAL  
RENEWAL RATES (existing groups)

DATED: 5/11/10

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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			
<b>COST SHARING</b>														
1	<b>EPO 25 SMART START (Limited Hospital Based Network)</b> \$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				366.69	880.06	678.38	1100.07			
2	<b>EPO 30/50 1000A Select</b> \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	No Referral	\$15 (Generic Only)	SELECT PRIME	318.25	911.29	318.25	753.47	588.99	956.28				
3	<b>EPO 30/50 1000 Select</b> \$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	No Referral	\$20/30/50	SELECT PRIME	372.44	1068.46	372.44	883.54	689.26	1118.87				
4	<b>EPO 25/1000 Select</b> \$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	399.55	1147.10	399.55	948.62	739.42	1200.22				
5	<b>EPO 15/1000 Select</b> \$15 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	416.74	1196.95	416.74	989.88	771.23	1251.78				
6*	<b>PPO 15/1000 Select</b> <table border="0"> <tr> <td><b>In Network</b></td> <td><b>Out of Network</b></td> </tr> <tr> <td>\$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.</td> <td>\$1000/2000 Deductible 80% to \$3000/6000 coin max.</td> </tr> </table>	<b>In Network</b>	<b>Out of Network</b>	\$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	\$1000/2000 Deductible 80% to \$3000/6000 coin max.	No Referral	\$15/30/50	SELECT PRIME	645.10	1859.18	645.10	1537.93	1193.69	1936.83
<b>In Network</b>	<b>Out of Network</b>													
\$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	\$1000/2000 Deductible 80% to \$3000/6000 coin max.													
7*	<b>PPO 30/50 1000 Select</b> <table border="0"> <tr> <td><b>In Network</b></td> <td><b>Out of Network</b></td> </tr> <tr> <td>PCP \$30 / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.</td> <td>\$1000/2000 Ded. 80% to \$3000/6000 coin max.</td> </tr> </table>	<b>In Network</b>	<b>Out of Network</b>	PCP \$30 / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	\$1000/2000 Ded. 80% to \$3000/6000 coin max.	No Referral	\$20/30/50	SELECT PRIME	582.34	1677.18	582.34	1387.31	1077.58	1748.58
<b>In Network</b>	<b>Out of Network</b>													
PCP \$30 / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	\$1000/2000 Ded. 80% to \$3000/6000 coin max.													
8*	<b>PPO 25/1000 Select</b> <table border="0"> <tr> <td><b>In Network</b></td> <td><b>Out of Network</b></td> </tr> <tr> <td>\$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.</td> <td>\$1000/2000 Deductible 80% to \$3000/6000</td> </tr> </table>	<b>In Network</b>	<b>Out of Network</b>	\$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	\$1000/2000 Deductible 80% to \$3000/6000	No Referral	\$20/30/50	SELECT PRIME	615.06	1772.09	615.06	1465.85	1138.13	1846.75
<b>In Network</b>	<b>Out of Network</b>													
\$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	\$1000/2000 Deductible 80% to \$3000/6000													
<b>HMO PLANS</b>														
9*	<b>HMO SUPER VALUE</b> \$20 Copay \$500 Hospital Copay	Referral	\$100 Deductible \$10 (Generic Only) Name Brand Discount	PRIME	528.18	1472.82	528.18	1267.64	995.71	1614.66				
10*	<b>HMO 25/40A</b> \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	550.08	1533.90	550.08	1320.21	1036.99	1681.61				
11*	<b>HMO VALUE</b> \$20 Copay \$500 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	592.06	1650.94	592.06	1420.95	1116.13	1809.94				
12*	<b>HMO 20</b> \$20 Copay \$250 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	613.13	1709.72	613.13	1471.51	1155.86	1874.35				
13*	<b>HMO 5</b> \$5 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	644.05	1795.92	644.05	1545.71	1214.12	1968.86				
14*	<b>HMO 15</b> \$15 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	630.50	1758.14	630.50	1513.19	1188.59	1927.44				
15*	<b>HMO 10</b> \$10 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	638.82	1781.36	638.82	1533.16	1204.26	1952.87				
<b>POS PLANS</b>														
16	<b>POS 20/1000</b> <table border="0"> <tr> <td><b>In Network</b></td> <td><b>Out of Network</b></td> </tr> <tr> <td>\$20 Copay \$250 Hospital Copay</td> <td>\$1000/2000 Deductible 70% to \$2000/\$4000 OOP</td> </tr> </table>	<b>In Network</b>	<b>Out of Network</b>	\$20 Copay \$250 Hospital Copay	\$1000/2000 Deductible 70% to \$2000/\$4000 OOP	Referral	\$7/30/50	PRIME	710.96	1982.53	710.96	1706.30	1340.24	2173.41
<b>In Network</b>	<b>Out of Network</b>													
\$20 Copay \$250 Hospital Copay	\$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: 5/11/10

Please visit our web site, [www.LIAHealthAlliance.com](http://www.LIAHealthAlliance.com), and read the benefit summaries before finalizing your selections.

RATE SHEET	Monthly										
	Two Tier Rates						Four Tier Rates				
PLAN #	<b>HIP Plans with VYTRA Premium Network</b>										
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
<b>HMO PLANS</b>											
<b>DIRECT ACCESS HMO PLANS</b>											
1	<b>HMO 20</b> \$20 Copay \$250 Hospital Copay		No Referral	\$10/20/50	Vytra Premium	751.69	2091.97	751.69	1804.06	1411.47	2288.92
2	<b>HMO 15</b> \$15 Copay \$250 Hospital Copay		No Referral	\$10/20/50	Vytra Premium	762.75	2122.76	762.75	1830.62	1432.26	2322.60
3	<b>HMO 10</b> \$10 Copay No Hospital Copay		No Referral	\$10/20/50	Vytra Premium	778.07	2165.40	778.07	1867.38	1461.03	2369.23
<b>POS PLANS</b>											
4	<b>POS 20/1000</b>		Referral	\$10/20/40 Covered only at participating pharmacies	Vytra Premium	770.28	2143.71	770.28	1848.67	1446.37	2345.50
	In Network \$20 Copay Hospital Copay \$250										
5	<b>POS 15/500</b>		Referral	\$7/15/35 Covered only at participating pharmacies	Vytra Premium	846.05	2354.59	846.05	2030.53	1588.65	2576.22
	In Network \$15 Copay No Hospital Copay										
6	<b>POS 10/250</b>		Referral	\$5/10/35 Covered only at participating pharmacies	Vytra Premium	976.53	2717.68	976.53	2343.69	1833.69	2973.52
	In Network \$10 Copay No Hospital Copay										

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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.**