

RELEASE DATE: 11/19/10



TRADITIONAL  
RENEWAL RATES

REVISED  
4th QUARTER 2010

DECEMBER

DATED:8/16/10

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									
	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>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	375.91	964.21	375.91	751.82	755.96	1157.05
2	HMO 20A \$20 Copay \$500 Hospital Copay	No Referral	\$0 Generic Brand Name \$250 Ded \$25 Copay, Max \$2000	Atlantis	393.05	1008.17	393.05	786.10	790.42	1209.81
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0/30/50	Atlantis	409.88	1051.34	409.88	819.76	824.27	1261.61
4	HMO 20 \$20 Copay \$500 Hospital Copay	No Referral	\$20/30/40	Atlantis	419.62	1076.33	419.62	839.24	843.86	1291.59
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay	No Referral	\$0/30/50	Atlantis	467.02	1197.91	467.02	934.04	939.18	1437.49
6	HMO 20 Plus \$20 Copay No Hospital Copay	No Referral	\$20/30/40	Atlantis	480.32	1232.02	480.32	960.64	965.92	1478.42
<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	436.27	1119.03	436.27	872.54	877.34	1342.84
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	451.34	1157.69	451.34	902.68	907.64	1389.22
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	462.84	1187.18	462.84	925.68	930.77	1424.62
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	571.29	1465.36	571.29	1142.58	1148.86	1758.43
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	543.55	1394.21	543.55	1087.10	1093.08	1673.05
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	626.68	1607.43	626.68	1253.36	1260.25	1928.92

Rates are subject to NYS Insurance Department Approval

NOTE: Atlantis POS plans are available for Renewals only.

**TRADITIONAL  
RENEWAL RATES**

**4th QUARTER 2010**

**DECEMBER  
REVISED**

DATED: 11/22/10 (10/13/10) (9/9/10)

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

RATE SHEET PLAN #	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>COST SHARING</b>										
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	341.17	993.79	341.17	818.86	635.13	1028.74
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 Brand \$30, Non Pref \$50	National	416.98	1213.16	416.98	1000.75	775.38	1256.16
3	CS EPO 40/2000A \$40 Copay \$0 Copay Children \$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP	No Referral	\$15 GENERIC ONLY	National	303.35	882.17	303.35	725.52	565.84	914.67
4	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 Brand \$30, Non Pref \$50	National	467.67	1360.62	467.67	1122.43	869.15	1408.22
5	CS EPO 40/1000B \$40 Copay \$0 Copay Children \$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	\$15 GENERIC ONLY Mail Order Unlimited	National	354.04	1029.19	354.04	847.20	659.61	1066.73
6	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 Brand \$30, Non Pref \$50	National	485.15	1411.22	485.15	1164.35	1001.46	1460.63
7	CS EPO 30/500 (Available for existing enrollees only) \$30 Copay \$0 Copay Children \$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	508.00	1476.92	508.00	1219.17	943.73	1529.17
8	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 Brand \$25, Non Pref \$50	National	669.59	1946.18	669.59	1607.04	1242.70	2013.99
9	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 \$100 Ded, Brand \$25, Non Pref \$50	National	660.60	1920.06	660.60	1585.42	1226.04	1986.97
<b>NON COST SHARING</b>										
10	EPO 40/1000 \$40 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	498.96	1451.38	498.96	1197.51	927.04	1502.11
11	EPO 40/1000A \$40 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$15 GENERIC ONLY	National	385.33	1119.95	385.33	922.28	717.50	1160.62
12	EPO 30/1000A \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$15 GENERIC ONLY	National	421.56	1224.98	421.56	1009.21	784.51	1269.30

TRADITIONAL  
RENEWAL RATES (continued)

4th QUARTER 2010  
DECEMBER  
REVISED

RATE SHEET PLAN #	EMBLEM HEALTH										
	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>NON COST SHARING (continued)</b>											
13	EPO 30/1000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	535.19	1556.41	535.19	1284.44	994.05	1610.79
	\$30 Copay	\$1000 Hospital Copay									
	\$0 Copay Children										
14	EPO 30/500 (Available for existing enrollees)		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	579.70	1685.50	579.70	1391.27	1076.38	1744.31
	\$30 Copay	\$500 Hospital Copay									
	\$0 Copay Children										
15	EPO 20 (existing enrollees only)		No Referral	\$0/30/50	National	769.83	2236.83	769.83	1847.56	1428.11	2314.67
	\$20 Copay	\$0 Hospital Copay									
	\$0 Copay Children										
16	PPO 25/1000 (2 tier available for existing enrollees only)		No Referral	\$0/25/40	National	1034.11	3003.30	1034.11	2481.90	1916.86	3107.57
	In Network \$25 Copay	Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP									
	\$0 Copay Children										
	\$500 Hospital Copay										
17	PPO 30/1000 (2 tier available for existing enrollees only)		No Referral	\$0 Generic \$100 Ded, Brand 25, Non Pref \$50	National	815.43	2369.07	815.43	1957.00	1512.45	2451.46
	In Network \$30 Copay	Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP									
	\$0 Copay Children										
	\$500 Hospital, \$250 Amb										
<b>HMO- COMPREHEALTH</b>											
18	HMO-30/50/1000		Referral	\$15 Generic Only	Comprehealth	267.83	824.07	267.83	642.77	535.11	867.76
	\$30 PCP / \$50 Specialist Copay	\$1000 Hospital Copay									
	\$0 Copay Children										
19	HMO-30/50/500		Referral	\$15 Generic Only	Comprehealth	297.66	915.85	297.66	714.36	594.70	964.41
	\$30 PCP / \$50 Specialist Copay	\$500 Hospital Copay									
	\$0 Copay Children										
20	HMO-25/40/500A		Referral	\$25 Generic/\$35 Brand	Comprehealth	338.95	1042.93	338.95	813.49	677.22	1098.21
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay									
	\$0 Copay Children										
21	HMO-25/40/500		Referral	\$0 Generic \$30 Brand	Comprehealth	410.39	1262.73	410.39	984.93	819.95	1329.67
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay									
	\$0 Copay Children										
22	HMO-20/25/200		Referral	\$15 Generic Only	Comprehealth	362.67	1115.88	362.67	870.40	724.59	1175.04
	\$20 PCP / \$25 Specialist Copay	\$200 Hospital Copay									
	\$0 Copay Children										

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.
- 2) NY Metro (Comprehealth) is a limited network.
- 3) Existing enrollees ONLY can renew into Plan (#15 EPO 20).
- 4) Non Cost Sharing PPO Plans (#16 PPO 25/1000 and #17 PPO 30/1000A ) are no longer available with 2-Tier rates EXCEPT for existing enrollees.

TRADITIONAL  
**RENEWAL RATES (existing groups)**

4th QUARTER 2010  
**DECEMBER  
REVISED**

DATED: 11/22/10 (9/3/10)

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RATE SHEET PLAN #	<b>EMBLEM HEALTH (formerly GHI renewals)</b>		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	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 \$100 Ded, Brand \$25, Non Pref \$50	National	750.35	2180.34	750.35	1800.83	1392.07	2256.22
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 Brand \$25, Non Pref \$50	National	759.34	2206.46	759.34	1822.45	1408.73	2283.24
<b>NON COST SHARING</b>										
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 \$100 Ded, Brand \$25, Non Pref \$50	National	888.64	2581.38	888.64	2132.72	1647.91	2671.10
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	1359.32	3946.42	1359.32	3262.37	2518.66	4083.18

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**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: 8/17/10

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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			395.06	948.14	789.33	1280.00		
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	331.12	1006.52	331.12	784.37	661.85	1074.51		
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	386.67	1177.43	386.67	917.69	772.83	1254.48		
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	414.44	1262.88	414.44	984.34	828.31	1344.45		
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	431.99	1316.88	431.99	1026.46	863.38	1401.31		
6*	<b>PPO 15/1000 Select</b> <table border="0"> <tr> <td><b>In Network</b> \$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.</td> <td><b>Out of Network</b> \$1000/2000 Deductible 80% to \$3000/6000 coin max.</td> </tr> </table>	<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	666.11	2037.27	666.11	1588.38	1331.17	2159.89
<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.											
7*	<b>PPO 30/50 1000 Select</b> <table border="0"> <tr> <td><b>In Network</b> PCP \$30 / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.</td> <td><b>Out of Network</b> \$1000/2000 Ded. 80% to \$3000/6000 coin max.</td> </tr> </table>	<b>In Network</b> PCP \$30 / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	<b>Out of Network</b> \$1000/2000 Ded. 80% to \$3000/6000 coin max.	No Referral	\$20/30/50	SELECT PRIME	603.15	1843.53	603.15	1437.26	1205.36	1955.88
<b>In Network</b> PCP \$30 / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	<b>Out of Network</b> \$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> \$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.</td> <td><b>Out of Network</b> \$1000/2000 Deductible 80% to \$3000/6000</td> </tr> </table>	<b>In Network</b> \$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	<b>Out of Network</b> \$1000/2000 Deductible 80% to \$3000/6000	No Referral	\$20/30/50	SELECT PRIME	635.50	1943.06	635.50	1514.90	1269.99	2060.69
<b>In Network</b> \$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	<b>Out of Network</b> \$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	548.44	1600.19	548.44	1316.25	1095.79	1776.95		
10*	<b>HMO 25/40A</b> \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	570.89	1665.69	570.89	1370.12	1140.62	1849.67		
11*	<b>HMO VALUE</b> \$20 Copay \$500 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	613.93	1791.25	613.93	1473.42	1226.63	1989.12		
12*	<b>HMO 20</b> \$20 Copay \$250 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	635.00	1852.75	635.00	1523.98	1268.74	2057.39		
13*	<b>HMO 5</b> \$5 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	666.72	1945.30	666.72	1600.11	1332.09	2160.17		
14*	<b>HMO 15</b> \$15 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	652.63	1904.20	652.63	1566.30	1303.96	2114.52		
15*	<b>HMO 10</b> \$10 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	661.19	1929.18	661.19	1586.84	1321.06	2142.26		
<b>POS PLANS</b>												
16	<b>POS 20/1000</b> <table border="0"> <tr> <td><b>In Network</b> \$20 Copay \$250 Hospital Copay</td> <td><b>Out of Network</b> \$1000/2000 Deductible 70% to \$2000/\$4000 OOP</td> </tr> </table>	<b>In Network</b> \$20 Copay \$250 Hospital Copay	<b>Out of Network</b> \$1000/2000 Deductible 70% to \$2000/\$4000 OOP	Referral	\$7/30/50	PRIME	739.32	2157.17	739.32	1774.35	1477.14	2395.40
<b>In Network</b> \$20 Copay \$250 Hospital Copay	<b>Out of Network</b> \$1000/2000 Deductible 70% to \$2000/\$4000 OOP											

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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)**

**4th QUARTER 2010  
DECEMBER**

DATED: 8/17/10

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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	777.80	2269.41	777.80	1866.71	1554.02	2520.07	
2	<b>HMO 15</b> \$15 Copay \$250 Hospital Copay	No Referral	\$10/20/50	Vytra Premium	789.11	2302.42	789.11	1893.87	1576.63	2556.71	
3	<b>HMO 10</b> \$10 Copay No Hospital Copay	No Referral	\$10/20/50	Vytra Premium	804.71	2347.93	804.71	1931.29	1607.80	2607.23	
<b>POS PLANS</b>											
4	<b>POS 20/1000</b> 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	800.55	2335.83	800.55	1921.31	1599.48	2593.78	
5	<b>POS 15/500</b> 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	877.11	2559.20	877.11	2105.04	1752.43	2841.81	
6	<b>POS 10/250</b> 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	1010.42	2948.13	1010.42	2425.00	2018.83	3273.74	

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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.**