

RELEASE DATE: 10/13/10



TRADITIONAL
RENEWAL RATES

4th QUARTER 2010
OCTOBER & NOVEMBER

DATED:8/16/10

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	Monthly Two Tier Rates		Monthly Four Tier Rates		
							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	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		
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	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**

**REVISED
4th QUARTER 2010
OCTOBER & NOVEMBER**

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

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

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												
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	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	\$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	In Network \$40 Copay - Annual Ded for hospital based services \$1000/3000 80% to \$3000/9000 OOP \$0 Copay Children	Out of Network \$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	In Network \$40 Copay - Annual Ded for hospital based services \$1000/3000 80% to \$3000/9000 OOP \$0 Copay Children	Out of Network \$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
NON COST SHARING												
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)

REVISED
4th QUARTER 2010
OCTOBER & NOVEMBER

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)										
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 \$0 Copay Children	\$1000 Hospital Copay									
14	EPO 30/500		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	579.70	1685.50	579.70	1391.27	1076.38	1744.31
	\$30 Copay \$0 Copay Children	\$500 Hospital Copay									
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 Copay Children	\$0 Hospital Copay									
16	PPO 25/1000 (2 tier available for existing enrollees only)		No Referral	\$0/25/40	National	1034.11	3003.3	1034.11	2481.90	1916.86	3107.57
	In Network \$25 Copay \$0 Copay Children \$500 Hospital Copay	Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP									
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 \$0 Copay Children \$500 Hospital, \$250 Amb.	Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP									
	HMO- COMPREHEALTH										
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 \$0 Copay Children	\$1000 Hospital Copay									
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 \$0 Copay Children	\$500 Hospital Copay									
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 \$0 Copay Children	\$500 Hospital Copay									
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 \$0 Copay Children	\$500 Hospital Copay									
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 \$0 Copay Children	\$200 Hospital Copay									

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
OCTOBER & NOVEMBER
REVISED

DATED: 11/2210 (9/3/10)

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 \$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	
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 \$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	

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: 8/17/10

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

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		
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			395.06	948.14	789.33	1280.00			
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	331.12	1006.52	331.12	784.37	661.85	1074.51			
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	386.67	1177.43	386.67	917.69	772.83	1254.48			
4	EPO 25/1000 Select \$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	EPO 15/1000 Select \$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*	PPO 15/1000 Select <table border="0"> <tr> <td>In Network \$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.</td> <td>Out of Network \$1000/2000 Deductible 80% to \$3000/6000 coin max.</td> </tr> </table>	In Network \$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	Out of Network \$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	
In Network \$15 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	Out of Network \$1000/2000 Deductible 80% to \$3000/6000 coin max.												
7*	PPO 30/50 1000 Select <table border="0"> <tr> <td>In Network PCP \$30 / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.</td> <td>Out of Network \$1000/2000 Ded. 80% to \$3000/6000 coin max.</td> </tr> </table>	In Network PCP \$30 / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	Out of Network \$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	
In Network PCP \$30 / \$50 Specialist Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	Out of Network \$1000/2000 Ded. 80% to \$3000/6000 coin max.												
8*	PPO 25/1000 Select <table border="0"> <tr> <td>In Network \$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.</td> <td>Out of Network \$1000/2000 Deductible 80% to \$3000/6000</td> </tr> </table>	In Network \$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	Out of Network \$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	
In Network \$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	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	548.44	1600.19	548.44	1316.25	1095.79	1776.95			
10*	HMO 25/40A \$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*	HMO VALUE \$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*	HMO 20 \$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*	HMO 5 \$5 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	666.72	1945.30	666.72	1600.11	1332.09	2160.17			
14*	HMO 15 \$15 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	652.63	1904.20	652.63	1566.30	1303.96	2114.52			
15*	HMO 10 \$10 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	661.19	1929.18	661.19	1586.84	1321.06	2142.26			
POS PLANS													
16	POS 20/1000 <table border="0"> <tr> <td>In Network \$20 Copay \$250 Hospital Copay</td> <td>Out of Network \$1000/2000 Deductible 70% to \$2000/\$4000 OOP</td> </tr> </table>	In Network \$20 Copay \$250 Hospital Copay	Out of Network \$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	
In Network \$20 Copay \$250 Hospital Copay	Out of Network \$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
OCTOBER & NOVEMBER**

DATED: 8/17/10

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 #	HIP Plans with VYTRA Premium Network										
	COPAY	Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	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	777.80	2269.41	777.80	1866.71	1554.02	2520.07	
2	HMO 15 \$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	HMO 10 \$10 Copay No Hospital Copay	No Referral	\$10/20/50	Vytra Premium	804.71	2347.93	804.71	1931.29	1607.80	2607.23	
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	800.55	2335.83	800.55	1921.31	1599.48	2593.78	
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	877.11	2559.20	877.11	2105.04	1752.43	2841.81	
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	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.