

RELEASE DATE: 1/24/11



TRADITIONAL
RENEWAL RATES

1st QUARTER 2011

DATED: 12/10/10

Please visit our web site, 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
HMO PLANS											
1	HMO 25/40A \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0 Generic Only	Atlantis	380.63	976.32	380.63	761.26	765.45	1171.58	
2	HMO 20A \$20 Copay \$500 Hospital Copay	No Referral	\$0 Generic Only	Atlantis	397.77	1020.28	397.77	795.54	799.92	1224.34	
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	No Referral	\$0/30/50	Atlantis	415.46	1065.65	415.46	830.92	835.49	1278.79	
4	HMO 20 \$20 Copay \$500 Hospital Copay	No Referral	\$20/30/40	Atlantis	425.20	1090.64	425.20	850.40	855.08	1308.77	
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay	No Referral	\$0/30/50	Atlantis	472.60	1212.22	472.60	945.20	950.40	1454.66	
6	HMO 20 Plus \$20 Copay No Hospital Copay	No Referral	\$20/30/40	Atlantis	485.90	1246.33	485.90	971.80	977.14	1495.60	
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 Only	Atlantis	443.79	1138.32	443.79	887.58	892.46	1365.99	
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 Only	Atlantis	458.86	1176.98	458.86	917.72	922.77	1412.37	
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	471.22	1208.68	471.22	942.44	947.62	1450.42	
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	579.67	1486.85	579.67	1159.34	1165.72	1784.22	
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	551.93	1415.70	551.93	1103.86	1109.93	1698.84	
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	635.06	1628.93	635.06	1270.12	1277.11	1954.71	

Rates are subject to NYS Insurance Department Approval

NOTE: Atlantis POS plans are available for existing enrollees only.

The above rates include adjustments for Health Care Reform (PPACA).



TRADITIONAL
RENEWAL RATES

1st QUARTER 2011

REVISED: 1/21/11 (12/3/10) (12/2/10)

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	Monthly Two Tier Rates		Monthly Four Tier Rates			
PLAN #					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	341.17	993.79	341.17	818.86	635.13	1028.74
2	CS EPO 40/1000C										
	\$40 Copay \$0 Copay Children	\$1000/3000 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 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	393.51	1145.50	393.51	944.41	731.91	1185.70
3	CS EPO 40/2000B										
	\$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 \$3,000 threshold; 50% thereafter Mail Order Unlimited	National	387.11	1126.98	387.11	929.09	720.11	1166.56
4	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
5	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
6	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
7	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
8	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	904.46	1460.63
9	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



TRADITIONAL

1st QUARTER 2011

RENEWAL RATES (continued)

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
COST SHARING (continued)										
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 40/1000B \$40 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	446.51	1299.28	446.51	1071.65	830.01	1344.77
13	EPO 30/1000B \$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
14	EPO 30/1000 \$30 Copay \$0 Copay Children \$1000 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	535.19	1556.41	535.19	1284.44	994.05	1610.79
15	EPO 30/500* (Available for existing enrollees) \$30 Copay \$0 Copay Children \$500 Hospital Copay	No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	579.70	1685.50	579.70	1391.27	1076.38	1744.31
16	EPO 20* (existing enrollees only) \$20 Copay \$0 Copay Children \$0 Hospital Copay	No Referral	\$0/30/50	National	769.83	2236.83	769.83	1847.56	1428.11	2314.67
17	PPO 40/500/3000 <u>In Network</u> \$40 Copay \$0 Copay Children \$500 x 3 Hospital Copay; \$500 Amb. <u>Out of Network</u> \$3000/9000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR	No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			682.19	1637.26	1265.99	2051.78
18	PPO 30/300/2000 <u>In Network</u> \$30 Copay \$0 Copay Children \$300 x 5 Hospital Copay; \$250 Amb. <u>Out of Network</u> \$2000/6000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR	No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National			791.98	1900.75	1469.10	2381.15
19	PPO 30/300/2000A <u>In Network</u> \$30 Copay \$0 Copay Children \$300 x 5 Hospital Copay; \$250 Amb. <u>Out of Network</u> \$2000/6000 Annual Deductible 70% to \$3,000/9,000 OOP 70th percentile UCR	No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			740.06	1776.17	1373.08	2225.43



TRADITIONAL
RENEWAL RATES (continued)

1st QUARTER 2011

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)											
20	PPO 25/1000* (2 tier available for existing enrollees only)		No Referral	\$0/25/40	National	1034.11	3003.30	1034.1	2481.90	1916.9	3107.57
	<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									
21	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	1512.5	2451.46
	<u>In Network</u> \$30 Copay \$0 Copay Children \$500 Hospital, \$250 Amb	<u>Out of Network</u> \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP									
HMO- COMPREHEALTH											
22	HMO-30/50/1000 \$30 PCP / \$50 Specialist Copay \$0 Copay Children		Referral	\$15 Generic Only	Comprehealth	273.20	799.68	273.20	643.14	524.60	850.72
23	HMO-30/50/500 \$30 PCP / \$50 Specialist Copay \$0 Copay Children		Referral	\$15 Generic Only	Comprehealth	303.62	888.69	303.62	714.73	583.02	945.47
24	HMO-25/40/500A \$25 PCP / \$40 Specialist Copay \$0 Copay Children		Referral	\$25 Generic/\$35 Brand	Comprehealth	345.82	1013.11	345.82	814.81	664.08	1076.88
25	HMO-25/40/500 \$25 PCP / \$40 Specialist Copay \$0 Copay Children		Referral	\$0 Generic \$30 Brand	Comprehealth	419.05	1231.62	419.05	990.53	804.69	1304.89
26	HMO-20/25/200 \$20 PCP / \$25 Specialist Copay \$0 Copay Children		Referral	\$15 Generic Only	Comprehealth	369.96	1082.69	369.96	870.77	710.37	1151.98

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. Additional plans with RX thresholds may also be selected.
- 2) NY Metro (Comprehealth) is a limited network.
- 3) Existing enrollees ONLY can renew into Plan (#16 EPO 20).
- 4) Non Cost Sharing PPO Plans (#20 PPO 25/1000 and #21 PPO 30/1000) are no longer available with 2-Tier rates EXCEPT for existing enrollees.

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



**TRADITIONAL
RENEWAL RATES (existing groups)**

1st QUARTER 2011

DATED: 1/21/11 (12/3/10)

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
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	No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National	888.64	2581.38	888.64	2132.72	1647.91	2671.10
	<u>Out of Network</u> \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP									
4	PPO 20/500 (2 tier available for existing enrollees only) <u>In Network</u> \$20 Copay \$0 Copay Children No Hospital Copay	No Referral	\$0/25/40	National	1359.32	3946.42	1359.32	3262.37	2518.66	4083.18
	<u>Out of Network</u> \$500/1500 Annual Deductible 80% to \$2000/6000 OOP									

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)

REVISED: 1/24/11 (11/3/10)

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RATE SHEET PLAN #	HIP	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
COST SHARING											
1	EPO 30/50 1000A Select PESLT2253D	\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	No Referral	\$15 (Generic Only)	SELECT PRIME	331.12	976.16	331.12	784.37	636.11	1032.72
2	EPO 30/50 1000 Select PESLT2254	\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.	No Referral	\$20/30/50	SELECT PRIME	386.67	1141.92	386.67	917.69	742.78	1205.70
3	EPO 25/1000 Select PESLT2051	\$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	414.44	1224.79	414.44	984.34	796.10	1292.17
4	EPO 15/1000 Select PESLT2053	\$15 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	431.99	1277.16	431.99	1026.46	829.81	1346.82
5*	PPO 15/1000 Select PFSLT5026	In Network \$15 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$15/30/50	SELECT PRIME	666.11	1975.82	666.11	1588.38	1279.40	2075.89
		Out of Network \$1000/2000 Deductible 80% to \$3000/6000 coin max.									
6*	PPO 30/50 1000 Select PFSLT5087	In Network PCP \$30 / \$50 Specialist Copay, \$1000 ded hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	602.14	1784.92	602.14	1434.84	1156.55	1876.69
		Out of Network \$1000/2000 Ded. 80% to \$3000/6000 coin max.									
7*	PPO 25/1000 Select PFSLT5008	In Network \$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.	No Referral	\$20/30/50	SELECT PRIME	635.50	1884.46	635.50	1514.90	1220.60	1980.55
		Out of Network \$1000/2000 Deductible 80% to \$3000/6000									
8	PPO 30/50 2000 Select** PFSLT6107	In Network \$30 PCP/\$50 Specialist Copay, \$2000 ded hospital based services. 80% coin, \$5,000 coin max.	No Referral	Not Covered	SELECT PRIME			445.36	1058.29	885.50	1388.52
		Out of Network \$4000/8000 Deductible 60% coins to \$10,000/20,000 coins max.									
HMO PLANS											
9*	HMO SUPER VALUE PHSTD4912	\$20 Copay \$500 Hospital Copay	Referral	\$100 Deductible \$10 (Generic Only) Name Brand Discount	PRIME	559.47	1553.01	559.47	1317.17	1074.32	1742.15
10*	HMO 25/40A PHSTD4057	\$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	582.58	1619.68	582.58	1373.71	1118.70	1814.12
11*	HMO VALUE PHSTD4913	\$20 Copay \$500 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	626.60	1742.94	626.60	1478.27	1203.22	1951.17
12*	HMO 20 PHSTD4914	\$20 Copay \$250 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	648.08	1802.58	648.08	1528.83	1244.51	2018.09
13*	HMO 5 PHSTD4915	\$5 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	680.43	1892.47	680.43	1605.07	1306.65	2118.86
14*	HMO 15 PHSTD4917	\$15 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	666.06	1852.60	666.06	1571.26	1279.07	2074.12
15*	HMO 10 PHSTD4916	\$10 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	674.78	1876.83	674.78	1591.80	1295.82	2101.31
POS PLANS											
16	POS 20/1000 PPSTD2363	In Network \$20 Copay \$250 Hospital Copay	Referral	\$7/30/50	PRIME	754.45	2097.95	754.45	1779.30	1448.77	2349.39
		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

** Replacement plan for SmartStart enrollees.



**TRADITIONAL
RENEWAL RATES (existing groups)**

1st QUARTER 2011

DATED: 11/3/10

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

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.