

RELEASE DATE: 4/15/11



TRADITIONAL
RENEWAL RATES

2nd QUARTER 2011

DATED: 2/10/11

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 Only	Atlantis	403.06	1033.85	403.06	806.12	810.55	1240.62
2	HMO 20A \$20 Copay \$500 Hospital Copay		No Referral	\$0 Generic Only	Atlantis	421.25	1080.51	421.25	842.50	847.13	1296.61
3	HMO 25/40 \$25 PCP / \$40 Specialist Copay \$500 Hospital Copay		No Referral	\$0/30/50	Atlantis	440.57	1130.06	440.57	881.14	885.99	1356.07
4	HMO 20 \$20 Copay \$500 Hospital Copay		No Referral	\$20/30/40	Atlantis	450.91	1156.58	450.91	901.82	906.78	1387.90
5	HMO 25/40 Plus \$25 PCP / \$40 Specialist Copay No Hospital Copay		No Referral	\$0/30/50	Atlantis	501.20	1285.58	501.20	1002.40	1007.91	1542.69
6	HMO 20 Plus \$20 Copay No Hospital Copay		No Referral	\$20/30/40	Atlantis	515.31	1321.77	515.31	1030.62	1036.29	1586.12
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	469.99	1205.52	469.99	939.98	945.15	1446.63
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	485.98	1246.54	485.98	971.96	977.31	1495.85
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	499.65	1281.60	499.65	999.30	1004.80	1537.92
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	614.70	1576.71	614.70	1229.40	1236.16	1892.05
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	585.28	1501.24	585.28	1170.56	1177.00	1801.49
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	673.47	1727.45	673.47	1346.94	1354.35	2072.94

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

2nd QUARTER 2011

DATED: 3/7/11

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RATE SHEET	EMBLEM HEALTH											
	COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILDREN	FAMILY	
PLAN #	COST SHARING					Monthly Two Tier Rates		Monthly Four Tier Rates				
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	371.88	1083.23	371.88	892.56	692.29	1121.33
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	428.92	1248.60	428.92	1029.41	797.78	1292.41
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	421.96	1228.41	421.96	1012.71	784.92	1271.55
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	454.52	1322.82	454.52	1090.82	845.16	1396.21
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	330.66	961.57	330.66	790.82	616.76	996.99
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	509.77	1483.07	509.77	1223.45	947.37	1534.96
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	385.91	1121.82	385.91	923.45	718.97	1162.74
8	CS EPO 30/2000*	\$30 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	473.60	1378.17	473.60	1136.63	880.46	1426.45
9	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	528.82	1538.28	528.82	1269.14	982.59	1592.08
10	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	553.73	1610.49	553.73	1328.90	1028.67	1666.79

RENEWAL RATES (continued)

RATE SHEET PLAN #	EMBLEM HEALTH		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
NON COST SHARING											
11	EPO 40/1000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	543.87	1582.01	543.87	1305.28	1010.47	1637.30
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
12	EPO 40/1000A		No Referral	\$15 GENERIC ONLY	National	420.01	1220.76	420.01	1005.28	782.07	1265.08
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
13	EPO 40/1000B		No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	486.69	1416.23	486.69	1168.09	904.71	1465.80
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
14	EPO 30/1000B		No Referral	\$15 GENERIC ONLY	National	459.50	1335.24	459.50	1100.04	855.11	1383.54
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay									
15	EPO 30/1000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	583.36	1696.49	583.36	1400.04	1083.51	1755.76
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay									
16	EPO 30/500* (Available for existing enrollees)		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	631.88	1837.20	631.88	1516.48	1173.25	1901.30
	\$30 Copay \$0 Copay Children	\$500 Hospital Copay									
17	EPO 20* (existing enrollees only)		No Referral	\$0/30/50	National	839.12	2348.15	839.12	2013.84	1556.64	2522.99
	\$20 Copay \$0 Copay Children	\$0 Hospital Copay									
18	PPO 40/500/3000		No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			743.58	1748.61	1379.93	2236.44
	<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									
19	PPO 30/300/2000		No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National			863.26	2071.82	1601.32	2595.45
	<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									
20	PPO 30/300/2000A		No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			806.66	1936.02	1496.66	2425.72
	<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									

RENEWAL RATES (continued)

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)											
21	PPO 25/1000* (2 tier available for existing enrollees only)		No Referral	\$0/25/40	National	1182.84	3434.99	1182.8	2838.82	2192.5	3554.20
	<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									
22	PPO 30/1000* (2 tier available for existing enrollees only)		No Referral	\$0 Generic \$100 Ded, Brand 25, Non Pref \$50	National	968.62	2813.71	968.62	2324.67	1796.2	2911.50
	<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											
23	HMO-30/50/1000 \$30 PCP / \$50 Specialist Copay \$0 Copay Children		Referral	\$15 Generic Only	Comprehealth	284.43	790.23	284.43	597.30	546.18	885.72
24	HMO-30/50/500 \$30 PCP / \$50 Specialist Copay \$0 Copay Children		Referral	\$15 Generic Only	Comprehealth	316.10	878.22	316.10	663.81	606.99	984.34
25	HMO-25/40/500A \$25 PCP / \$40 Specialist Copay \$0 Copay Children		Referral	\$25 Generic/\$35 Brand	Comprehealth	360.04	1000.31	360.04	756.10	691.37	1121.16
26	HMO-25/40/500 \$25 PCP / \$40 Specialist Copay \$0 Copay Children		Referral	\$0 Generic \$30 Brand	Comprehealth	436.27	1212.10	436.27	916.18	837.76	1358.54
27	HMO-20/25/200 \$20 PCP / \$25 Specialist Copay \$0 Copay Children		Referral	\$15 Generic Only	Comprehealth	385.14	1070.04	385.14	808.80	739.58	1199.93

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 (#17 EPO 21).
- 4) Non Cost Sharing PPO Plans (#21 PPO 25/1000 and #22 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)

2nd QUARTER 2011

DATED: 3/7/11

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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)	FAMILY	
NON COST SHARING											
3	PPO 30/1000G (2 tier available for existing enrollees only)		No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National	968.62	2813.71	968.62	2324.67	1796.22	2911.50
	<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	PPO 20/500 (2 tier available for existing enrollees only)		No Referral	\$0/25/40	National	1481.66	4301.6	1481.66	3555.98	2745.34	4450.67
	<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:

EH plans with prescription retail maximums are no longer available and have been replaced with corresponding plans without retail maximums.

TRADITIONAL

RENEWAL RATES (existing groups)

DATED: 3/7/11

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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	361.82	988.23	361.82	757.24	695.11	1128.32
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	424.46	1160.33	424.46	888.78	815.39	1323.38
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	455.00	1244.24	455.00	952.91	874.03	1418.49
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	474.31	1297.29	474.31	993.46	911.11	1478.61
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	680.35	1863.38	680.35	1426.14	1306.78	2120.21
		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	614.99	1683.79	614.99	1288.86	1181.27	1916.67
		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	648.55	1775.97	648.55	1359.33	1245.70	2021.16
		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			436.39	913.83	838.30	1360.52
		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	582.41	1618.10	582.41	1223.06	1118.39	1813.63
10*	HMO 25/40A PHSTD4057	\$25 PCP / \$40 Specialist Copay \$500 Hospital Copay	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	606.46	1684.93	606.46	1273.56	1164.58	1888.52
11*	HMO VALUE PHSTD4913	\$20 Copay \$500 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	652.29	1812.25	652.29	1369.81	1252.58	2031.23
12*	HMO 20 PHSTD4914	\$20 Copay \$250 Hospital Copay	Referral	\$50 Deductible \$7/30/50	PRIME	674.66	1874.43	674.66	1416.79	1295.53	2100.89
13*	HMO 5 PHSTD4915	\$5 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	708.33	1967.95	708.33	1487.49	1360.21	2205.74
14*	HMO 15 PHSTD4917	\$15 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	693.38	1926.42	693.38	1456.10	1331.51	2159.19
15*	HMO 10 PHSTD4916	\$10 Copay No Hospital Copay	Referral	\$7/30/50	PRIME	702.46	1951.65	702.46	1475.16	1348.94	2187.46
POS PLANS											
16	POS 20/1000 PPSTD2363	In Network \$20 Copay \$250 Hospital Copay	Referral	\$7/30/50	PRIME	785.40	2182.07	785.40	1649.33	1508.20	2445.74
		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

** Replacement plan for SmartStart enrollees.

**TRADITIONAL
RENEWAL RATES (existing groups)**

2nd QUARTER 2011

REVISED: 4/15/11

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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	826.43	2296.07	826.43	1735.53	1587.01	2573.51
2	HMO 15 \$15 Copay \$250 Hospital Copay	No Referral	\$10/20/50	Vytra Premium	838.43	2329.42	838.43	1760.72	1610.03	2610.87
3	HMO 10 \$10 Copay No Hospital Copay	No Referral	\$10/20/50	Vytra Premium	855.00	2375.45	855.00	1795.51	1641.87	2662.47
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	850.57	2363.14	850.57	1786.18	1633.33	2648.67
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	931.98	2589.32	931.98	1957.15	1789.66	2902.18
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	1073.64	2982.91	1073.64	2254.64	2061.73	3343.31

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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.