

RELEASE DATE: 7/8/11



TRADITIONAL
RENEWAL RATES

3rd QUARTER 2011
July - August - September

DATED: 5/6/11

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	Monthly Two Tier Rates		Monthly Four Tier Rates	
							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 2Q RATES ARE GOOD THROUGH AUGUST 2011.

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

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



TRADITIONAL
RENEWAL RATES

3rd QUARTER 2011

DATED: 6/17/11

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
	COST SHARING											
1	CS EPO 40/1000A*			No Referral	None	National	386.76	1126.56	386.76	928.26	719.98	1166.18
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP										
2	CS EPO 40/1000C			No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	446.08	1,298.54	446.08	1,070.59	829.69	1344.11
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP										
3	CS EPO 40/2000B			No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$3,000 threshold; 50% thereafter Mail Order Unlimited	National	438.84	1277.55	438.84	1053.22	816.31	1322.41
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP										
4	CS EPO 40/2000			No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	472.71	1375.73	472.71	1134.46	878.96	1423.98
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP										
5	CS EPO 40/2000A			No Referral	\$15 GENERIC ONLY	National	343.89	1000.03	343.89	822.46	641.43	1036.87
	\$40 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP										
6	CS EPO 40/1000*			No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	530.17	1542.39	530.17	1272.39	985.26	1596.36
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP										
7	CS EPO 40/2500/80			No Referral	\$15 Generic Only	National	348.33	1012.91	348.33	833.11	649.64	1083.46
	\$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$4,500/13,500 OOP										
8	CS EPO 40/2500/80 A			No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	423.77	1233.87	423.77	1017.06	788.45	1319.49
	\$40 Copay \$0 Copay Children	\$2,500/7,500 Annual Deductible for hospital based services with 80% to \$4,500/13,500 OOP										
9	CS EPO 40/1000B*			No Referral	\$15 GENERIC ONLY	National	401.35	1166.69	401.35	960.39	747.73	1209.25
	\$40 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP										
10	CS EPO 30/2000*			No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	492.55	1433.29	492.55	1182.10	915.67	1483.51
	\$30 Copay \$0 Copay Children	\$2000/6000 Annual Deductible for hospital based services with 80% to \$3,000/9,000 OOP										
11	CS EPO 30/1000*			No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	512.84	1492.13	512.84	1230.79	953.21	1544.38
	\$30 Copay \$0 Copay Children	\$1000/3000 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP										
12	CS EPO 30/500* (Available for existing enrollees only)			No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	575.89	1674.91	575.89	1382.06	1069.81	1733.47
	\$30 Copay \$0 Copay Children	\$500/1500 Annual Deductible for hospital based services with 90% to \$500/1,500 OOP										

RENEWAL RATES (continued)

RATE SHEET PLAN #	EMBLEM HEALTH		Referral No Ref	RX	NET WORK	Monthly Two Tier Rates		Monthly Four Tier Rates			
	COPYAY					EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
NON COST SHARING											
13	EPO 40/1000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	565.63	1645.28	565.63	1357.49	1050.88	1702.79
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
14	EPO 40/1000A		No Referral	\$15 GENERIC ONLY	National	436.81	1269.58	436.81	1045.49	813.35	1315.68
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
15	EPO 40/1000B		No Referral	\$0 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	506.16	1472.87	506.16	1214.81	940.89	1524.43
	\$40 Copay \$0 Copay Children	\$1000 Hospital Copay									
16	EPO 30/1000B		No Referral	\$15 GENERIC ONLY	National	477.88	1388.64	477.88	1144.04	889.32	1438.88
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay									
17	EPO 30/1000		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	606.70	1764.34	606.70	1456.04	1126.85	1825.99
	\$30 Copay \$0 Copay Children	\$1000 Hospital Copay									
18	EPO 30/500* (Available for existing enrollees)		No Referral	\$0 Generic Brand \$30, Non Pref \$50	National	657.16	1910.68	657.16	1577.14	1220.17	1977.35
	\$30 Copay \$0 Copay Children	\$500 Hospital Copay									
19	EPO 40/1000/750		No Referral	\$10 Generic, \$50 ded Brand \$30, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National	512.25	1490.54	512.25	1229.44	952.16	1551.71
	\$40 Copay \$0 Copay Children \$100 ER	\$1000 Hospital Copay \$750 Ambulatory									
20	EPO 20* (existing enrollees only)		No Referral	\$0/30/50	National	872.69	2535.67	872.69	2094.39	1618.90	2623.91
	\$20 Copay \$0 Copay Children	\$0 Hospital Copay									
21	PPO 40/500/3000		No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			773.33	1855.99	1435.13	2325.90
	<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									
22	PPO 30/300/2000		No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National			897.79	2154.69	1665.37	2699.26
	<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									
23	PPO 30/300/2000A		No Referral	\$0 Generic, \$50 ded Brand \$25, Non Pref \$50 \$1,000 threshold; 50% thereafter Mail Order Unlimited	National			838.93	2013.46	1556.53	2522.75
	<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									
24	PPO 40/500/5000		No Referral	\$10 Generic, \$50 ded Brand \$25, Non Pref \$50	National	820.34	2383.91	820.34	1968.81	1522.08	2548.82
	<u>In Network</u> \$40 Copay \$0 Copay Children \$500 x 3 Hospital Copay	<u>Out of Network</u> \$5,000/15,000 Annual Deductible 70% to \$8,000/24,000 OOP 70th percentile UCR									

RENEWAL RATES (continued)

RATE SHEET	PLAN #	EMBLEM HEALTH										
		COPAY		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	FAMILY	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
NON COST SHARING (continued)												
25	PPO 25/1000* (2 tier available for existing enrollees only)	In Network \$25 Copay \$0 Copay Children \$500 Hospital Copay	Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP	No Referral	\$0/25/40	National	1230.16	3572.38	1230.2	2952.36	2280.2	3696.36
26	PPO 30/1000* (2 tier available for existing enrollees only)	In Network \$30 Copay \$0 Copay Children \$500 Hospital, \$250 Amb	Out of Network \$1000/3000 Annual Deductible 70% to \$3000/9000 OOP	No Referral	\$0 Generic \$100 Ded, Brand 25, Non Pref \$50	National	1007.37	2926.25	1007.37	2417.65	1868.1	3027.95
HMO- COMPREHEALTH												
27	HMO-30/50/1000	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	292.95	856.10	292.95	688.43	562.55	912.25
28	HMO-30/50/1000A	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$1000 Hospital Copay	Referral	\$15 Generic \$100 ded Brand \$35, Non Pref \$75	Comprehealth	339.77	992.93	339.77	798.46	652.46	1058.04
29	HMO-30/50/500	\$30 PCP / \$50 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	325.57	951.41	325.57	765.09	625.19	1013.83
30	HMO-25/40/500A	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$25 Generic/\$35 Brand	Comprehealth	370.84	1083.72	370.84	871.47	712.12	1154.80
31	HMO-25/40/500	\$25 PCP / \$40 Specialist Copay \$0 Copay Children	\$500 Hospital Copay	Referral	\$0 Generic \$30 Brand	Comprehealth	449.35	1313.16	449.35	1055.97	862.88	1399.28
32	HMO-20/25/200	\$20 PCP / \$25 Specialist Copay \$0 Copay Children	\$200 Hospital Copay	Referral	\$15 Generic Only	Comprehealth	396.70	1159.30	396.00	932.24	761.79	1235.33

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 (#25 PPO 25/1000 and #26 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)**

3rd QUARTER 2011

DATED: 5/19/11

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)		No Referral	\$0 Generic \$100 Ded, Brand \$25, Non Pref \$50	National	1007.37	2926.25	1007.37	2417.65	1868.06	3027.95
	<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	1540.93	4473.66	1540.93	3698.21	2855.16	4628.69
	<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.

RENEWAL RATES (existing groups)

DATED: 5/19/11

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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	No Referral	\$15 (Generic Only)	SELECT PRIME	371.91	1097.88	371.91	882.27	714.47	1159.74
	\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.										
2	EPO 30/50 1000 Select	PESLT2254	No Referral	\$20/30/50	SELECT PRIME	436.43	1290.41	436.43	1,037.12	838.37	1360.66
	\$30 PCP / \$50 Specialist Copay, \$1000 ded. hospital based services. 90% coin, \$1000 coin max.										
3	EPO 25/1000 Select	PESLT2051	No Referral	\$20/30/50	SELECT PRIME	467.89	1384.29	467.89	1112.62	898.77	1458.61
	\$25 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.										
4	EPO 15/1000 Select	PESLT2053	No Referral	\$20/30/50	SELECT PRIME	487.78	1443.66	487.78	1160.37	936.97	1520.56
	\$15 Copay, \$1000 ded. hospital based services. 90% coin, \$500 coin max.										
5*	PPO 15/1000 Select	PFSLT5026	No Referral	\$15/30/50	SELECT PRIME	700.39	2078.12	700.39	1670.65	1345.26	2182.64
	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.									
6*	PPO 30/50 1000 Select	PFSLT5087	No Referral	\$20/30/50	SELECT PRIME	633.06	1877.18	633.06	1509.04	1215.97	1972.97
	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.									
7*	PPO 25/1000 Select	PFSLT5008	No Referral	\$20/30/50	SELECT PRIME	667.62	1980.32	667.62	1591.98	1282.33	2080.59
	In Network \$25 Copay, \$1000 ded. hospital based services 90% coin, \$500 coin max.	Out of Network \$1000/2000 Deductible 80% to \$3000/6000									
8	PPO 30/50 2000 Select**	PFSLT6107	No Referral	Not Covered	SELECT PRIME			448.71	1066.59	861.94	1398.90
	In Network \$30 PCP/\$50 Specialist Copay, \$2000 ded hospital based services 80% coin, \$5,000 coin max.	Out of Network \$4000/8000 Deductible 60% coins to \$10,000/20,000 coins max.									
HMO PLANS											
9*	HMO SUPER VALUE	PHSTD4912	Referral	\$100 Deductible \$10 (Generic Only) Name Brand Discount	PRIME	599.88	1666.65	599.88	1409.71	1151.95	1868.03
	\$20 Copay	\$500 Hospital Copay									
10*	HMO 25/40A	PHSTD4057	Referral	\$50 Deductible \$20/\$30/\$50	PRIME	624.66	1735.50	624.66	1467.96	1199.53	1945.19
	\$25 PCP / \$40 Specialist Copay	\$500 Hospital Copay									
11*	HMO VALUE	PHSTD4913	Referral	\$50 Deductible \$7/30/50	PRIME	671.85	1866.60	671.85	1578.84	1290.16	2092.14
	\$20 Copay	\$500 Hospital Copay									
12*	HMO 20	PHSTD4914	Referral	\$50 Deductible \$7/30/50	PRIME	694.89	1930.62	694.89	1632.98	1334.41	2163.89
	\$20 Copay	\$250 Hospital Copay									
13*	HMO 5	PHSTD4915	Referral	\$7/30/50	PRIME	729.60	2027.06	729.60	1714.55	1401.05	2271.97
	\$5 Copay	No Hospital Copay									
14*	HMO 15	PHSTD4917	Referral	\$7/30/50	PRIME	714.19	1984.24	714.19	1678.33	1371.45	2223.99
	\$15 Copay	No Hospital Copay									
15*	HMO 10	PHSTD4916	Referral	\$7/30/50	PRIME	723.54	2010.22	723.54	1700.30	1389.43	2253.10
	\$10 Copay	No Hospital Copay									
POS PLANS											
16	POS 20/1000	PPSTD2363	Referral	\$7/30/50	PRIME	808.98	2247.59	808.98	1901.11	1553.48	2519.16
	In Network \$20 Copay \$250 Hospital Copay	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)**

3rd QUARTER 2011

DATED: 5/19/11

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

RATE SHEET	Monthly									
	Two Tier Rates					Monthly 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	851.23	2364.98	851.23	2000.38	1634.59	2650.73
2	HMO 15 \$15 Copay \$250 Hospital Copay	No Referral	\$10/20/50	Vytra Premium	863.60	2399.35	863.60	2029.45	1658.35	2689.26
3	HMO 10 \$10 Copay No Hospital Copay	No Referral	\$10/20/50	Vytra Premium	880.65	2446.71	880.65	2069.50	1691.08	2742.34
POS PLANS										
4	POS 20/1000	Referral	\$10/20/40 Covered only at participating pharmacies	Vytra Premium	839.18	2331.49	839.18	1972.09	1611.47	2613.21
	<u>In Network</u> \$20 Copay Hospital Copay \$250									
5	POS 15/500	Referral	\$7/15/35 Covered only at participating pharmacies	Vytra Premium	931.98	2589.32	931.98	1957.15	1789.66	2902.18
	<u>In Network</u> \$15 Copay No Hospital Copay									
6	POS 10/250	Referral	\$5/10/35 Covered only at participating pharmacies	Vytra Premium	1073.64	2982.91	1073.64	2254.64	2061.73	3343.31
	<u>In Network</u> \$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.