



CONSUMER DRIVEN
NEW BUSINESS & RENEWAL

DATED: 5/5/08 4/21/08 (4/17/08)

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

RATE SHEET PLAN #	Monthly Four Tier Rates								
	ATLANTIS		Referral No Ref	RX	NET WORK	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD(ren)	FAMILY
1	POS 20/2000 HRA Option #1								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$10 Generic Brand Name \$250 ded. \$25 Copay, Max. \$2000	Atlantis	331.17	662.34	665.98	1019.34
2	POS 20/2000 HRA Option #2								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$250 Deductible \$7/30/50	Atlantis	341.67	683.34	687.10	1051.66
3	POS 20/2000 HRA Option #3								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$100 Deductible \$7/30/50	Atlantis	350.12	700.24	704.09	1077.67
4	POS 20/2000 HRA Option #4								
	<u>In Network</u> Copay \$20 Hospital Copay \$500	<u>Out of Network</u> Deductible \$2,000/\$4,000 70% to \$5,000/\$10,000 OOP	No Referral	\$7/30/50	Atlantis	355.74	711.48	715.39	1094.97

Rates are subject to NYS Insurance Department Approval.

The HRA Administration Fee is included in the above rates.

Option A: Covers Reimbursement of Out-of-Network Deductible Only, Up to \$2,000 - single and \$4,000 - family.

Option B: Covers Reimbursement of Out-of-Network Deductible Only, Up to \$1,000 - single and \$2,000 - family.

Option C: Covers Reimbursement of any eligible healthcare expense, Up to \$1,000 - single and \$2,000 - family.

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RATE SHEET PLAN #	GHI				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	
HSA HIGH DEDUCTIBLE EPO PLANS											
1	OPTION #1 INDEXED*										
	In Network Deductible \$1100/\$2200 90% Coinsurance \$5500/\$11000 OOP	No Referral	Subject to plan deductible RX \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order	National	245.56	626.18	245.56	540.23	466.56	724.39	
2	OPTION #2										
	In Network Deductible \$2500/\$5000 70% Coinsurance \$4750/\$9500 OOP	No Referral	Subject to plan deductible RX \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order	National	177.15	451.73	177.15	389.73	336.58	522.59	
3	OPTION #3 INDEXED*										
	In Network Deductible \$2,900/\$5,800 100%	No Referral	Covered in full after deductible	National	203.37	518.61	203.37	447.43	386.42	599.96	
4	OPTION #4 INDEXED*										
	In Network Deductible \$5,600/\$11,200 100%	No Referral	Covered in full after deductible	National	149.15	380.32	149.15	328.12	283.37	439.97	
HSA HIGH DEDUCTIBLE PPO PLANS WITH SHARED DEDUCTIBLES											
5	OPTION #1 INDEXED*										
	In Network Deductible \$1100/\$2200 80% Coinsurance \$3100/\$6200 OOP	Out of Network Deductible \$2200/\$4400 60% Coinsurance \$6200/\$12400 OOP	No Referral	Subject to plan deductible \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order (voluntary)	National	314.34	801.57	314.34	691.55	597.25	927.30
6	OPTION #2										
	In Network Deductible \$2500/\$5000 100%	Out of Network Deductible \$5000/\$10000 80% Coinsurance \$7000/\$14000 OOP	No Referral	Covered in full after deductible	National	276.33	704.63	276.33	607.92	525.02	815.16
7	OPTION #3										
	In Network Deductible \$2500/\$5000 80% Coinsurance \$4500/\$9000 OOP	Out of Network Deductible \$5000/\$10000 OOP 60% Coinsurance \$9000/\$18000 OOP	No Referral	Subject to plan deductible \$0/\$20/\$40 Retail \$0/\$40/\$80 Mail Order (voluntary)	National	246.98	629.80	246.98	543.35	469.26	728.58
8	OPTION #4										
	In Network Deductible \$5000/\$10000 100%	Out of Network Deductible \$10000/\$20000 80% to \$12000/\$24000 OOP	No Referral	Covered in full after deductible	National	202.09	515.32	202.09	444.59	383.96	596.15

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NOTES:

GHI PPO requires 50% participation in GHI products (class carve-outs allowed).
All GHI prescriptions are Voluntary Home Delivery and are NO LONGER mandatory generic
*** INDEXED - deductible and out of pocket max will increase annually according to IRS guidelines.**



3rd QUARTER 2008

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	PerfectHealth		Referral No Ref	RX	EMPLOYEE ONLY	EMPLOYEE +SPOUSE	EMPLOYEE +CHILD	FAMILY
	COPAY							
1	PPO HSA PLAN 22P							
	Provider Network: Multiplan	Hospital Network: HIP						
	<u>In Network</u> Deductible \$2,500/\$5,000 100% Coinsurance Lifetime Maximum \$ Unlimited	<u>Out of Network</u> Deductible \$2,500/\$5,000 70% \$3,000/\$3,000 Max OOP Lifetime Maximum Unlimited	No Referral	Subject to Out of Network Deductible 70% Coinsurance after Retail Discount Card	258.43	516.85	453.80	712.23
2	PPO HSA PLAN 30P							
	Provider Network: Multiplan	Hospital Network: HIP						
	<u>In Network</u> Deductible \$5,000/\$10,000 100% Coinsurance Lifetime Maximum Unlimited	<u>Out of Network</u> Deductible \$5,000/\$10,000 70% \$3,000/\$3,000 Max OOP Lifetime Maximum Unlimited	No Referral	Subject to Out of Network Deductible 70% Coinsurance after Retail Discount Card	196.52	393.04	345.09	541.61

Rates are subject to NYS Insurance Department Approval.
Families with 7 or more members will be charged higher rates.
Parent +Child is for one child. More than one child is Family Rate.