

LIA HEALTH ALLIANCE

ATLANTIS POS 20/1000

2008 BENEFIT PLAN

Plan 10

DATED: 8/29/07 (8/6/07)

Please read Insurer Descriptions and Focus Provider Directories before making benefit plan selections.

BENEFIT CHOICES	IN NETWORK	OUT OF NETWORK
FINANCIAL		
Network Copay	\$20 co-payment(PCP) \$20 co-payment(specialist)	subject to deductible and co-insurance
Annual Deductible Out of Network (Individual/Family)	\$1,000/\$2,500	\$1,000/\$2,500
Out of Network Coinsurance/Coinsurance Max	70/30	70/30
Out of Pocket Maximum	\$3,000/\$7,500	\$3,000/\$7,500
Annual Deductible In-Network (Individual/Family)	N/A	N/A
In-Network Coinsurance/Coinsurance Max	N/A	N/A
Out of Pocket Maximum	N/A	N/A
Lifetime Maximum Benefit	\$1,000,000	\$1,000,000
Max.Age for Dependent Children/Full-time Students	25	25
PRESCRIPTION DRUG CARD BENEFITS		
Generic/Name Brand/Non-formulary	\$20/30/40	N/A
ADULT & CHILDREN'S PREVENTIVE CARE		
Preventative: Well Baby, Well Child, Immunizations, Mammograms, Pap Tests, Annual Physical Exam	No co-payment \$20 co-payment	In network benefits only subject to deductible and co-insurance
Care Rendered Outside a Hospital Setting		
Primary Physician Office Visits	\$20 co-payment	subject to deductible and co-insurance
Specialist Office Visits	\$20 co-payment	subject to deductible and co-insurance
Laboratory Services	\$20 co-payment	subject to deductible and co-insurance
Radiology	\$20 co-payment	subject to deductible and co-insurance
HOSPITAL CARE		
Inpatient Facility Services	No co-payment	subject to deductible and co-insurance
Out Patient Facility Service (Ambulatory Surgery)	No co-payment	subject to deductible and co-insurance
In-Patient Physician and Surgeon Services	No co-payment	subject to deductible and co-insurance
Out-Patient Physician and Surgeon Services	N/A	subject to deductible and co-insurance
Semi-Private Room and Board	N/A	subject to deductible and co-insurance
All Drugs and Medications	\$20/30/40	subject to deductible and co-insurance
EMERGENCY CARE		
Emergency Room Copay	\$50 co-payment	\$50 co-payment
Emergency Room Professional Services	\$50 co-payment	\$50 co-payment
Ambulance Services when necessary	\$50 co-payment	\$50 co-payment
MATERNITY CARE		
Prenatal and Post-Natal Care	\$20 co-payment	subject to deductible and co-insurance
Hospital Service	No co-payment	subject to deductible and co-insurance
MENTAL HEALTH CARE (IN NETWORK ONLY)		
Outpatient Visits (20 visits per calendar year)	\$20 co-payment	In network benefits only
Inpatient Care (30 days per calendar year)	No co-payment	In network benefits only
SUBSTANCE ABUSE (IN NETWORK ONLY)		
Inpatient Detox. (7 days per calendar year)	No co-payment	In network benefits only
Inpatient Rehab. (Rider)	Rider available	Rider Available
Outpatient Rehab. (60 visits per calendar year)	\$20 co-payment	subject to deductible and co-insurance
ALTERNATIVE CARE SERVICES		
Skilled Nursing Facility (45 days per calendaryear)	No co-payment	subject to deductible and co-insurance
Home Health Care (60 visits per calendar year)	No co-payment	subject to deductible and co-insurance
Hospice (210 days combined with Outpatient)	No co-payment	subject to deductible and co-insurance
SHORT-TERM THERAPY (OUTPATIENT)		
*Physical Therapy, Occupational Therapy	\$20 co-pay	subject to deductible and co-insurance
Speech Therapy	\$20 co-pay	subject to deductible and co-insurance
CHIROPRACTIC CARE	\$20 co-payment	subject to deductible and co-insurance
DURABLE MED. EQUIPMENT/PROSTHETICS	No co-payment	subject to deductible and co-insurance
VISION	N/A	N/A
DENTAL	N/A	N/A

NOTE: This is a brief summary of benefits and should only be used as a guide. You must refer to the selected insurer's subscriber agreement for a complete description of requirements for coverage, covered services, limitations and exclusions.

* Inpatient 30 days per diagnosis per calendar year/ Outpatient 20 visits per diagnosis per calendar year