

LIA HEALTH ALLIANCE

2008 BENEFIT PLAN

Plan 16

GHI PPO 20/500

DATED: 7-1-07

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

BENEFIT CHOICES	IN NETWORK	OUT OF NETWORK
FINANCIAL		
Network Copay	\$20 Copay	NA
Dependant Child/Student Copay	\$0 Copay	
Annual Deductible Out of Network (Individual/Family)	NA	\$500/\$1500
Out of Network Coinsurance/Coinsurance Max	NA	80% \$2000/\$6000
Out of Pocket Maximum	NA	\$2500/\$7500
Annual Deductible In-Network (Individual/Family)	NA	NA
In-Network Coinsurance/Coinsurance Max	NA	NA
Out of Pocket Maximum	NA	NA
Lifetime Maximum Benefit	Unlimited	Unlimited
Max.Age for Dependent Children/Full-time Students	19/25	19/25
PRESCRIPTION DRUG CARD BENEFITS		
Generic/Name Brand/Non-formulary	\$0/\$25/\$40	In-network only
ADULT & CHILDREN'S PREVENTIVE CARE		
Preventative: Well Baby, Well Child, Immunizations, Mammograms, Pap Tests, Annual Physical Exam	Covered in full \$20 Copay/\$0 for Dep. Child/Student	Deductible and Coinsurance Deductible and Coinsurance
Care Rendered Outside a Hospital Setting		
Primary Physician Office Visits	\$20 Copay/\$0 for Dep. Child/Student	Deductible and Coinsurance
Specialist Office Visits	\$20 Copay/\$0 for Dep. Child/Student	Deductible and Coinsurance
Laboratory Services	\$20 Copay/\$0 for Dep. Child/Student	Deductible and Coinsurance
Radiology	\$20 Copay/\$0 for Dep. Child/Student	Deductible and Coinsurance
HOSPITAL CARE		
Inpatient Facility Services	No Copay	Deductible and Coinsurance
Out Patient Facility Service (Ambulatory Surgery)	Covered in full	Deductible and Coinsurance
In-Patient Physician and Surgeon Services	No Copay	Deductible and Coinsurance
Out-Patient Physician and Surgeon Services	Covered in full	Deductible and Coinsurance
Semi-Private Room and Board	No Copay	Deductible and Coinsurance
All Drugs and Medications	No Copay	Deductible and Coinsurance
EMERGENCY CARE		
Emergency Room Copay	\$50 Copay	\$50 Copay
Emergency Room Professional Services	Covered in full	100% of HIAA at 90th %ile
Ambulance Services when necessary	Covered up to UCR	Covered up to UCR
MATERNITY CARE		
Prenatal and Post-Natal Care	Covered in full	Deductible and Coinsurance
Hospital Service	No Copay	Deductible and Coinsurance
MENTAL HEALTH CARE		
Outpatient Visits/ 20 Visit Cal yr	\$20 Copay/\$0 for Dep. Child/Student	Deductible & Coinsurance
Inpatient Care/ 30 Days Cal yr	No Copay	Deductible & Coinsurance
SUBSTANCE ABUSE		
Inpatient Detox./ 7 Days Cal yr	No Copay	In-network only
Inpatient Rehab./ 30 Days Cal yr -60 days lifetime	No Copay	In-network only
Outpatient Visits/ 60 Days Cal yr	Covered in full	Deductible and Coinsurance
ALTERNATIVE CARE SERVICES		
Skilled Nursing Facility/ 60 Days Cal yr	Covered in full	Deductible and Coinsurance
Home Health Care/ 200 Visits Cal yr	Covered in full	Deductible and Coinsurance
Hospice/ 210 Days	Covered in full	In-network only
SHORT-TERM THERAPY		
Physical Therapy, Occupational/ 30 Days Cal yr	\$20 Copay/\$0 for Dep. Child/Student	Deductible and Coinsurance
Speech Therapy/ 10 Visit Cal yr	\$20 Copay/\$0 for Dep. Child/Student	Deductible and Coinsurance
CHIROPRACTIC CARE	\$20 Copay/\$0 for Dep. Child/Student	Deductible and Coinsurance
DURABLE MED. EQUIP/PROSTHETICS \$10,000 Cal yr	\$100 Deductible	In-network only
VISION	\$10 Copay for an eye exam every 24 months \$20 Copay for glasses or contacts every 24 months for dependents 19 and under	In-network only
DENTAL	NA	NA

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.