



GROUP HEALTH INCORPORATED
GHI-EPO SHARE Plan - PLH-SGC-225



EPO SHARE Small Group - Employee Groups of Two or More

Rates Effective: 7/1/08-9/30/08

ALBANY

EPO SHARE Plans offer In-Network Benefits Only with No Referrals to Specialists

	Office Visit Copay	Consultation/ER Copays	In-Network Deductible*	In-Network Coinsurance	In-Network Out-of-Pocket*	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40	\$55/\$100	\$2,000	80%/20%	\$10,000	\$157.14	\$403.99	\$157.14	\$301.30	\$345.69	\$467.22
2	\$40	\$55/\$100	\$2,000	80%/20%	\$3,000	\$165.84	\$426.18	\$165.84	\$317.83	\$364.84	\$492.90
3	\$40	\$55/\$100	\$1,000	90%/10%	\$500	\$194.75	\$499.87	\$194.75	\$372.74	\$428.41	\$578.15
4	\$30	\$45/\$100	\$2,000	80%/20%	\$2,000	\$177.62	\$456.21	\$177.62	\$340.21	\$390.75	\$527.64
5	\$30	\$45/\$100	\$1,000	80%/20%	\$2,000	\$194.40	\$499.01	\$194.40	\$372.10	\$427.66	\$577.14
6	\$30	\$45/\$100	\$1,000	90%/10%	\$500	\$204.72	\$525.31	\$204.72	\$391.70	\$450.36	\$607.58
7	\$30	\$45/\$100	\$500	90%/10%	\$500	\$217.75	\$558.53	\$217.75	\$416.44	\$479.02	\$646.01

In-Network Annual Max is Unlimited

Prescription Drug Options

Plan Option	Retail Copays/Coinsurance	Retail Deductible**	Retail Annual Max	Mail Order Copays/Coins	Mail Order (Unlimited)	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0/\$30/\$50	\$0	None	\$0/\$60/\$100	Voluntary	\$91.15	\$232.43	\$91.15	\$173.18	\$200.53	\$268.89
Q	\$0/\$30/\$50	\$100	None	\$0/\$60/\$100	Voluntary	\$84.43	\$215.29	\$84.43	\$160.41	\$185.74	\$249.06
R	\$0/\$30/\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	\$69.63	\$177.53	\$69.63	\$132.29	\$153.17	\$205.39
S	\$0/\$30/\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	\$53.36	\$136.07	\$53.36	\$101.38	\$117.39	\$157.41
T	\$0/\$30/\$50	\$50	\$750	\$0/\$60/\$100	Voluntary	\$48.93	\$124.78	\$48.93	\$92.98	\$107.66	\$144.35
O**	DISCOUNT ONLY - AVAILABLE WITH PLAN 3 ONLY (\$40/\$1,000/90%-10%/\$500) - NO ADDITIONAL COST										

* Family amounts are three times (3x) the Individual amounts.

** Deductible applies to Brand Preferred and Brand Non-Preferred drugs only

Sheets are for comparative purposes only and do not constitute a contract. Filed rates and Certificate of Insurance governs.

5/6/08



GROUP HEALTH INCORPORATED
GHI-EPO SHARE Plan - PLH-SGC-225

EPO SHARE Small Group - Employee Groups of Two or More

Rates Effective: 7/1/08-9/30/08

DOWNSTATE



EPO SHARE Plans offer In-Network Benefits Only with No Referrals to Specialists

	Office Visit Copay	Consultation/ER Copays	In-Network Deductible*	In-Network Coinsurance	In-Network Out-of-Pocket*	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40	\$55/\$100	\$2,000	80%/20%	\$10,000	\$200.01	\$513.32	\$200.01	\$382.76	\$440.01	\$593.70
2	\$40	\$55/\$100	\$2,000	80%/20%	\$3,000	\$211.10	\$541.59	\$211.10	\$403.82	\$464.41	\$626.41
3	\$40	\$55/\$100	\$1,000	90%/10%	\$500	\$247.92	\$635.46	\$247.92	\$473.77	\$545.39	\$735.01
4	\$30	\$45/\$100	\$2,000	80%/20%	\$2,000	\$226.10	\$579.84	\$226.10	\$432.33	\$497.41	\$670.66
5	\$30	\$45/\$100	\$1,000	80%/20%	\$2,000	\$247.48	\$634.36	\$247.48	\$472.95	\$544.44	\$733.72
6	\$30	\$45/\$100	\$1,000	90%/10%	\$500	\$260.62	\$667.87	\$260.62	\$497.92	\$573.35	\$772.50
7	\$30	\$45/\$100	\$500	90%/10%	\$500	\$277.22	\$710.19	\$277.22	\$529.44	\$609.86	\$821.46

In-Network Annual Max is Unlimited

Prescription Drug Options

Plan Option	Retail Copays/Coinsurance	Retail Deductible**	Retail Annual Max	Mail Order Copays/Coins	Mail Order (Unlimited)	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0/\$30/\$50	\$0	None	\$0/\$60/\$100	Voluntary	\$91.15	\$232.43	\$91.15	\$173.18	\$200.53	\$268.89
Q	\$0/\$30/\$50	\$100	None	\$0/\$60/\$100	Voluntary	\$84.43	\$215.29	\$84.43	\$160.41	\$185.74	\$249.06
R	\$0/\$30/\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	\$69.63	\$177.53	\$69.63	\$132.29	\$153.17	\$205.39
S	\$0/\$30/\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	\$53.36	\$136.07	\$53.36	\$101.38	\$117.39	\$157.41
T	\$0/\$30/\$50	\$50	\$750	\$0/\$60/\$100	Voluntary	\$48.93	\$124.78	\$48.93	\$92.98	\$107.66	\$144.35
O**	DISCOUNT ONLY - AVAILABLE WITH PLAN 3 ONLY (\$40/\$1,000/90%-10%/\$500) - NO ADDITIONAL COST										

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5/6/08



GROUP HEALTH INCORPORATED
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EPO SHARE Small Group - Employee Groups of Two or More

Rates Effective: 7/1/08-9/30/08

MID-HUDSON



EPO SHARE Plans offer In-Network Benefits Only with No Referrals to Specialists

	Office Visit Copay	Consultation/ER Copays	In-Network Deductible*	In-Network Coinsurance	In-Network Out-of-Pocket*	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40	\$55/\$100	\$2,000	80%/20%	\$10,000	\$177.08	\$454.84	\$177.08	\$339.19	\$389.56	\$526.05
2	\$40	\$55/\$100	\$2,000	80%/20%	\$3,000	\$186.89	\$479.86	\$186.89	\$357.83	\$411.15	\$555.00
3	\$40	\$55/\$100	\$1,000	90%/10%	\$500	\$219.48	\$562.94	\$219.48	\$419.73	\$482.82	\$651.11
4	\$30	\$45/\$100	\$2,000	80%/20%	\$2,000	\$200.17	\$513.71	\$200.17	\$383.06	\$440.36	\$594.16
5	\$30	\$45/\$100	\$1,000	80%/20%	\$2,000	\$219.09	\$561.96	\$219.09	\$419.01	\$481.98	\$649.97
6	\$30	\$45/\$100	\$1,000	90%/10%	\$500	\$230.72	\$591.62	\$230.72	\$441.10	\$507.56	\$684.29
7	\$30	\$45/\$100	\$500	90%/10%	\$500	\$245.41	\$629.07	\$245.41	\$469.00	\$539.88	\$727.62

In-Network Annual Max is Unlimited

Prescription Drug Options

Plan Option	Retail Copays/Coinsurance	Retail Deductible**	Retail Annual Max	Mail Order Copays/Coins	Mail Order (Unlimited)	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0/\$30/\$50	\$0	None	\$0/\$60/\$100	Voluntary	\$91.15	\$232.43	\$91.15	\$173.18	\$200.53	\$268.89
Q	\$0/\$30/\$50	\$100	None	\$0/\$60/\$100	Voluntary	\$84.43	\$215.29	\$84.43	\$160.41	\$185.74	\$249.06
R	\$0/\$30/\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	\$69.63	\$177.53	\$69.63	\$132.29	\$153.17	\$205.39
S	\$0/\$30/\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	\$53.36	\$136.07	\$53.36	\$101.38	\$117.39	\$157.41
T	\$0/\$30/\$50	\$50	\$750	\$0/\$60/\$100	Voluntary	\$48.93	\$124.78	\$48.93	\$92.98	\$107.66	\$144.35
O**	DISCOUNT ONLY - AVAILABLE WITH PLAN 3 ONLY (\$40/\$1,000/90%-10%/500) - NO ADDITIONAL COST										

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5/6/08



GROUP HEALTH INCORPORATED
GHI-EPO SHARE Plan - PLH-SGC-225



EPO SHARE Small Group - Employee Groups of Two or More

Rates Effective: 7/1/08-9/30/08

BUFFALO

EPO SHARE Plans offer In-Network Benefits Only with No Referrals to Specialists

	Office Visit Copay	Consultation/ER Copays	In-Network Deductible*	In-Network Coinsurance	In-Network Out-of-Pocket*	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40	\$55/\$100	\$2,000	80%/20%	\$10,000	\$153.15	\$393.82	\$153.15	\$293.72	\$336.91	\$455.46
2	\$40	\$55/\$100	\$2,000	80%/20%	\$3,000	\$161.63	\$415.45	\$161.63	\$309.83	\$355.58	\$480.48
3	\$40	\$55/\$100	\$1,000	90%/10%	\$500	\$189.80	\$487.26	\$189.80	\$363.34	\$417.53	\$563.56
4	\$30	\$45/\$100	\$2,000	80%/20%	\$2,000	\$173.11	\$444.71	\$173.11	\$331.64	\$380.82	\$514.33
5	\$30	\$45/\$100	\$1,000	80%/20%	\$2,000	\$189.46	\$486.42	\$189.46	\$362.72	\$416.80	\$562.57
6	\$30	\$45/\$100	\$1,000	90%/10%	\$500	\$199.52	\$512.05	\$199.52	\$381.82	\$438.92	\$592.24
7	\$30	\$45/\$100	\$500	90%/10%	\$500	\$212.21	\$544.43	\$212.21	\$405.93	\$466.85	\$629.69

In-Network Annual Max is Unlimited

Prescription Drug Options

Plan Option	Retail Copays/Coinsurance	Retail Deductible**	Retail Annual Max	Mail Order Copays/Coins	Mail Order (Unlimited)	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0/\$30/\$50	\$0	None	\$0/\$60/\$100	Voluntary	\$91.15	\$232.43	\$91.15	\$173.18	\$200.53	\$268.89
Q	\$0/\$30/\$50	\$100	None	\$0/\$60/\$100	Voluntary	\$84.43	\$215.29	\$84.43	\$160.41	\$185.74	\$249.06
R	\$0/\$30/\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	\$69.63	\$177.53	\$69.63	\$132.29	\$153.17	\$205.39
S	\$0/\$30/\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	\$53.36	\$136.07	\$53.36	\$101.38	\$117.39	\$157.41
T	\$0/\$30/\$50	\$50	\$750	\$0/\$60/\$100	Voluntary	\$48.93	\$124.78	\$48.93	\$92.98	\$107.66	\$144.35
O**	DISCOUNT ONLY - AVAILABLE WITH PLAN 3 ONLY (\$40/\$1,000/90%-10%/\$500) - NO ADDITIONAL COST										

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5/6/08



GROUP HEALTH INCORPORATED
GHI-EPO SHARE Plan - PLH-SGC-225



EPO SHARE Small Group - Employee Groups of Two or More

Rates Effective: 7/1/08-9/30/08

SYRACUSE

EPO SHARE Plans offer In-Network Benefits Only with No Referrals to Specialists

	Office Visit Copay	Consultation/ER Copays	In-Network Deductible*	In-Network Coinsurance	In-Network Out-of-Pocket*	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40	\$55/\$100	\$2,000	80%/20%	\$10,000	\$145.17	\$373.48	\$145.17	\$278.57	\$319.36	\$431.93
2	\$40	\$55/\$100	\$2,000	80%/20%	\$3,000	\$153.21	\$393.98	\$153.21	\$293.83	\$337.05	\$455.64
3	\$40	\$55/\$100	\$1,000	90%/10%	\$500	\$179.91	\$462.03	\$179.91	\$344.55	\$395.77	\$534.38
4	\$30	\$45/\$100	\$2,000	80%/20%	\$2,000	\$164.09	\$421.71	\$164.09	\$314.50	\$360.98	\$487.72
5	\$30	\$45/\$100	\$1,000	80%/20%	\$2,000	\$179.59	\$461.23	\$179.59	\$343.95	\$395.08	\$533.44
6	\$30	\$45/\$100	\$1,000	90%/10%	\$500	\$189.11	\$485.53	\$189.11	\$362.06	\$416.04	\$561.56
7	\$30	\$45/\$100	\$500	90%/10%	\$500	\$201.15	\$516.21	\$201.15	\$384.91	\$442.51	\$597.05

In-Network Annual Max is Unlimited

Prescription Drug Options

Plan Option	Retail Copays/Coinsurance	Retail Deductible**	Retail Annual Max	Mail Order Copays/Coins	Mail Order (Unlimited)	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0/\$30/\$50	\$0	None	\$0/\$60/\$100	Voluntary	\$91.15	\$232.43	\$91.15	\$173.18	\$200.53	\$268.89
Q	\$0/\$30/\$50	\$100	None	\$0/\$60/\$100	Voluntary	\$84.43	\$215.29	\$84.43	\$160.41	\$185.74	\$249.06
R	\$0/\$30/\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	\$69.63	\$177.53	\$69.63	\$132.29	\$153.17	\$205.39
S	\$0/\$30/\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	\$53.36	\$136.07	\$53.36	\$101.38	\$117.39	\$157.41
T	\$0/\$30/\$50	\$50	\$750	\$0/\$60/\$100	Voluntary	\$48.93	\$124.78	\$48.93	\$92.98	\$107.66	\$144.35
O**	DISCOUNT ONLY - AVAILABLE WITH PLAN 3 ONLY (\$40/\$1,000/90%-10%/500) - NO ADDITIONAL COST										

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5/6/08



GROUP HEALTH INCORPORATED
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EPO SHARE Small Group - Employee Groups of Two or More

Rates Effective: 7/1/08-9/30/08

ROCHESTER



EPO SHARE Plans offer In-Network Benefits Only with No Referrals to Specialists

	Office Visit Copay	Consultation/ER Copays	In-Network Deductible*	In-Network Coinsurance	In-Network Out-of-Pocket*	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40	\$55/\$100	\$2,000	80%/20%	\$10,000	\$151.15	\$388.74	\$151.15	\$289.93	\$332.53	\$449.57
2	\$40	\$55/\$100	\$2,000	80%/20%	\$3,000	\$159.53	\$410.08	\$159.53	\$305.83	\$350.95	\$474.27
3	\$40	\$55/\$100	\$1,000	90%/10%	\$500	\$187.33	\$480.95	\$187.33	\$358.64	\$412.09	\$556.26
4	\$30	\$45/\$100	\$2,000	80%/20%	\$2,000	\$170.85	\$438.96	\$170.85	\$327.36	\$375.86	\$507.68
5	\$30	\$45/\$100	\$1,000	80%/20%	\$2,000	\$186.99	\$480.12	\$186.99	\$358.03	\$411.37	\$555.29
6	\$30	\$45/\$100	\$1,000	90%/10%	\$500	\$196.92	\$505.42	\$196.92	\$376.88	\$433.20	\$584.57
7	\$30	\$45/\$100	\$500	90%/10%	\$500	\$209.45	\$537.37	\$209.45	\$400.68	\$460.76	\$621.53

In-Network Annual Max is Unlimited

Prescription Drug Options

Plan Option	Retail Copays/Coinsurance	Retail Deductible**	Retail Annual Max	Mail Order Copays/Coins	Mail Order (Unlimited)	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
P	\$0/\$30/\$50	\$0	None	\$0/\$60/\$100	Voluntary	\$91.15	\$232.43	\$91.15	\$173.18	\$200.53	\$268.89
Q	\$0/\$30/\$50	\$100	None	\$0/\$60/\$100	Voluntary	\$84.43	\$215.29	\$84.43	\$160.41	\$185.74	\$249.06
R	\$0/\$30/\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	\$69.63	\$177.53	\$69.63	\$132.29	\$153.17	\$205.39
S	\$0/\$30/\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	\$53.36	\$136.07	\$53.36	\$101.38	\$117.39	\$157.41
T	\$0/\$30/\$50	\$50	\$750	\$0/\$60/\$100	Voluntary	\$48.93	\$124.78	\$48.93	\$92.98	\$107.66	\$144.35
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UTICA



EPO SHARE Plans offer In-Network Benefits Only with No Referrals to Specialists

	Office Visit Copay	Consultation/ER Copays	In-Network Deductible*	In-Network Coinsurance	In-Network Out-of-Pocket*	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
1	\$40	\$55/\$100	\$2,000	80%/20%	\$10,000	\$145.17	\$373.48	\$145.17	\$278.57	\$319.36	\$431.93
2	\$40	\$55/\$100	\$2,000	80%/20%	\$3,000	\$153.21	\$393.98	\$153.21	\$293.83	\$337.05	\$455.64
3	\$40	\$55/\$100	\$1,000	90%/10%	\$500	\$179.91	\$462.03	\$179.91	\$344.55	\$395.77	\$534.38
4	\$30	\$45/\$100	\$2,000	80%/20%	\$2,000	\$164.09	\$421.71	\$164.09	\$314.50	\$360.98	\$487.72
5	\$30	\$45/\$100	\$1,000	80%/20%	\$2,000	\$179.59	\$461.23	\$179.59	\$343.95	\$395.08	\$533.44
6	\$30	\$45/\$100	\$1,000	90%/10%	\$500	\$189.11	\$485.53	\$189.11	\$362.06	\$416.04	\$561.56
7	\$30	\$45/\$100	\$500	90%/10%	\$500	\$201.15	\$516.21	\$201.15	\$384.91	\$442.51	\$597.05

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Prescription Drug Options

Plan Option	Retail Copays/Coinsurance	Retail Deductible**	Retail Annual Max	Mail Order Copays/Coins	Mail Order (Unlimited)	2 TIER RATES		4 TIER RATES			
						Individual	Family	Individual	Emp./Ch.	Emp./Sp.	Family
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Q	\$0/\$30/\$50	\$100	None	\$0/\$60/\$100	Voluntary	\$84.43	\$215.29	\$84.43	\$160.41	\$185.74	\$249.06
R	\$0/\$30/\$50	\$50	\$3,000	\$0/\$60/\$100	Voluntary	\$69.63	\$177.53	\$69.63	\$132.29	\$153.17	\$205.39
S	\$0/\$30/\$50	\$50	\$1,000	\$0/\$60/\$100	Voluntary	\$53.36	\$136.07	\$53.36	\$101.38	\$117.39	\$157.41
T	\$0/\$30/\$50	\$50	\$750	\$0/\$60/\$100	Voluntary	\$48.93	\$124.78	\$48.93	\$92.98	\$107.66	\$144.35
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