



**2009/2010
HIP SOLE PROPRIETOR
NEW BUSINESS RATES
Effective 4/1/09 through 3/31/10**

Tier	Plan #2	Plan #3
	HIP Select PPO 30/50 IN 2000 Rx \$300 Ded 20/30/50	HIP Select PPO 30/50 IN 2000 Rx \$100 Ded \$10 Generic Only
Individual Rate	419.49	380.01
Two Person Rate	795.10	723.01
Family Rate	1258.68	1143.90

Benefits		
Product	HIP select PPO	HIP select PPO
In Network Hospital Deductible	\$2,000 Individual / \$4,000 Family	\$2,000 Individual / \$4,000 Family
In Network Coinsurance	80%	80%
In Network Coinsurance Max	\$5,000 Individual / \$10,000 Family	\$5,000 Individual / \$10,000 Family
Out of Network Deductible	\$4,000 Individual / \$8,000 Family	\$4,000 Individual / \$8,000 Family
Out of Network Coinsurance	60%	60%
Out of Network Coinsurance Max	\$10,000 Individual / \$20,000 Family	\$10,000 Individual / \$20,000 Family
Primary Care Physician Copay	\$30	\$30
Specialist Copay	\$50	\$50
Diagnostic Lab/X-ray/EKG	Included in office visit copay	Included in office visit copay
In Patient Hospital Services	Subject to Ded & Coinsurance	Subject to Ded & Coinsurance
Ambulatory Surgery Services	Subject to Ded & Coinsurance	Subject to Ded & Coinsurance
Hospital Lab Services	Subject to Ded & Coinsurance	Subject to Ded & Coinsurance
ER Copay	\$150	\$150
Prescription Drug	\$300 Ded, \$20/\$30/\$50	\$100 Ded, \$10 generic only
Durable Medical Equipment	Not Covered	Not Covered
Out Patient Therapies - Physical, Occupational, Speech, Respiratory	30 Days subject to Ded & Coinsurance	30 Days subject to Ded & Coinsurance
Out Patient Therapies - Physical, Occupational, Speech, Respiratory	30 Visits, \$50 copay	30 Visits, \$50 copay
In Patient Mental Health Care	30 Days subject to Ded & Coinsurance	30 Days subject to Ded & Coinsurance
Out Patient Mental Health Care	40 visits, \$50 copay	40 visits, \$50 copay
Vision	Eye Exam \$25 Copay/Eye Glass \$0 Copay/Contacts \$25 Copay in network only	Eye Exam \$25 Copay/Eye Glass \$0 Copay/Contacts \$25 Copay in network only
Preventative Dental	Oral Exam \$5 Copay/Cleaning \$10 Copay (every 6 months)	Oral Exam \$5 Copay/Cleaning \$10 Copay (every 6 months)
Dependent Children covered to	End of Month in which they turn 19	End of Month in which they turn 19
Student Dependents covered to	End of Year in which they turn 23	End of Year in which they turn 23

NOTES:

All out of network services subject to deductible and coinsurance except emergency room copay \$150.
 \$10 monthly billing fee has been added to your premium.
 Additional HIP summary benefit plan information is available on line at www.LIAHealthAlliance.com and by clicking Enterprise Section.

DATED: 2/3/09