LIA Health Alliance
New York's Health Insurance Exchange

CS EPO 40/1000A

NATIONAL NETWORK

Benefit Summary EmblemHealth InBalance EPO $40/$1,000/90%/$500

BENEFIT HIGHLIGHTS EmblemHealth InBalance EPO provides in-network benefits only. Except for emergency hospital care, no out-of-network services are covered.

	Comments	In-network
Office Visits and Diagnostic Services for Dependent Children/Students		$0 Copay per visit
Office Visit, Including Outpatient Clinic Visits		$40 Copay per visit
Specialist Office Visits		$40 Copay per visit; No copay for unmarried dependent children and unmarried dependent students
Annual Deductible (Individual/Family)		$1,000/$3,000
Coinsurance		90%/10%
Annual Coinsurance Maximum (Individual/Family)		$500/$1,500
Inpatient Hospital Admission	PRECERTIFICATION: YES 365 days per confinement	Deductible and coinsurance
Emergency Room Care Facility Copay		$100 copay (waived if admitted)
Ambulatory Surgery Facility		Deductible and coinsurance
Annual Maximum Benefit Per Individual		Unlimited
Lifetime Maximum		Unlimited
Unmarried Dependent Children/Unmarried Dependent Students	Coverage effective until end of calendar year	Eligible to age 19/25
INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL		
Inpatient Hospital Admission	PRECERTIFICATION: YES 365 days per confinement	Deductible and coinsurance
Skilled Nursing Facility Care	PRECERTIFICATION: YES	Deductible and coinsurance
Inpatient Admission for Medical Rehabilitation (i.e. Physical Therapy, Physical Medicine and Rehabilitation)	PRECERTIFICATION: YES 30 days per calendar year	Deductible and coinsurance
Hospice Care - Inpatient and Outpatient	PRECERTIFICATION: YES 210 days per lifetime	Deductible and coinsurance
OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY		
Pre-Admission Testing		Deductible and coinsurance
Ambulatory Surgery Facility Charge (Free-standing)	PRECERTIFICATION: YES	Deductible and coinsurance
Ambulatory Surgery Facility Charge (Outpatient hospital)	PRECERTIFICATION: YES	Deductible and coinsurance
Home Health Care Services	PRECERTIFICATION: YES 200 visits per calendar year	20% Coinsurance (deductible waived)
Diagnostic Lab/Radiology	PRECERTIFICATION: YES Required for radiology services	Deductible and coinsurance
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full
MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN OR OTHER MEDICAL PROVIDER		
Office Visits and Diagnostic Services for Dependent Children/Students		No copay for unmarried dependent children and unmarried dependent students
Office Visit, Including Outpatient Clinic Visits		$40 Copay per visit
Specialist Office Visits		$40 Copay per visit; No copay for unmarried dependent children and unmarried dependent students

	Comments	In-network
Maternity Pre-Postnatal Care		Covered in full
Annual Physical Check-up (Adult)		Covered in full
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full
Chiropractic Care		$40 Copay per visit; No copay for unmarried dependent children and unmarried dependent students
Allergy Care		$40 Copay per visit; No copay for unmarried dependent children and unmarried dependent students
Physical Therapy, Osteopathic Manipulation, Occupational Therapy	30 visits per calendar year	$40 Copay per visit; No copay for unmarried dependent children and unmarried dependent students
Speech Therapy	10 Visits per calendar year	$40 Copay per visit; No copay for unmarried dependent children and unmarried dependent students
Outpatient Surgery	Office	Deductible and coinsurance
	Outpatient hospital	Deductible and coinsurance
	Ambulatory free-standing	Deductible and coinsurance
Inpatient Surgery		Deductible and coinsurance
Durable Medical Equipment (DME)	PRECERTIFICATION: YES when amount >$2,000; $10,000 calendar year maximum	Deductible and coinsurance
Diabetic Management: Education		$40 Copay per visit; no copay for unmarried dependent children and unmarried dependent students
Prescriptions		$5 Brand; $0 copay for unmarried dependent children and unmarried dependent students
Supplies	Covered under DME benefit, DME annual maximum does not apply	Covered in full
Diagnostic Laboratory	Performed in provider's office/ free-standing facility	$40 Diagnostic copay per visit; No copay for unmarried dependent children and unmarried dependent students
Diagnostic Radiology	PRECERTIFICATION: YES Performed in providers office/ free-standing facility. Precertification required In-network only	$40 Diagnostic copay per visit; No copay for unmarried dependent children and unmarried dependent students

WELL BABY AND CHILD CARE

	Comments	In-network
Well Baby and Well Child Care, Including Immunizations	Up to age 19	Covered in full

EMERGENCY COVERAGE

	Comments	In-network
Emergency Room Care Facility Copay		$100 Facility copay, waived if admitted
Emergency Ground Ambulance		Covered up to 100% of usual and customary amount, subject to deductible and coinsurance

INPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

	Comments	In-network
Inpatient Mental Health	PRECERTIFICATION: YES 30 days per calendar year; No limits for biologically-based mental illness and children with serious emotional disturbances	Deductible and coinsurance
Chemical Dependency: Detoxification	PRECERTIFICATION: YES 7 days per calendar year	Deductible and coinsurance
Chemical Dependency: Rehabilitation	PRECERTIFICATION: YES 30 days per calendar year	Deductible and coinsurance

	Comments	In-network
OUTPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY		
Outpatient Chemical Dependency	PRECERTIFICATION: YES 60 visits per calendar year	$40 Copay per visit; No copay for unmarried dependent children and unmarried dependent students
Outpatient Mental Health	PRECERTIFICATION: YES 30 visits per calendar year, no limits for biologically-based mental illness and children with serious emotional disturbances	$40 Copay per visit; No copay for unmarried dependent children and unmarried dependent students
VISION		
Exam	Performed by Davis Vision providers only; One eye exam every 24 months; Eligibility: all ages	$10 Office visit copay for adults; No copay for dependent children and unmarried dependent students
Frames, Lenses, Contacts	Eligibility: Children under the age of 19; every 24 months	Lenses, Frames, contacts (in lieu of frames and lenses) $20 copay

The EmblemHealth InBalance EPO is underwritten by Group Health Incorporated ("GHI") and provides in-network benefits only. Except for emergency hospital care, no out-of-network services are covered. Coverage is subject to all terms, conditions, limitations and exclusions set forth in the contract and certificate of insurance. Refer to GHI policy form number PLH-SGH-995, et. al.

EmblemHealth provides health benefit coverage and services through its subsidiary companies in New York State: Group Health Incorporated, HIP Health Plan of New York. The PerfectHealth Insurance Company, HIP Insurance Company of New York, GHI HMO Select, Inc., ConnectiCare of New York, Inc. and EmblemHealth Services Company LLC.

Covered services received from non-participating anesthesiologists, radiologists, pathologists and assistant surgeons while receiving covered services in a network hospital, facility, OPD, ambulatory facility or office is covered up to 100% of the 90th percentile of Ingenix Prevailing Healthcare Charges System. The benefits described herein are only highlights of the coverage available. The terms, limitations, conditions and exclusions of the insurance contract and certificate will govern.