LIA Health Alliance
New York's Health Insurance Exchange

CS EPO 40/2000A

NATIONAL NETWORK

Benefit Summary EmblemHealth InBalance PPO $40/$1,000/80%/$3,000

BENEFIT HIGHLIGHTS

	Comments	In-network	Out-of-network
Office Visits and Diagnostic Services for Dependent Child(ren)/Student(s)		$0 Copay per visit	Deductible and coinsurance
Office Visit, Including Outpatient Clinic Visits		$40 Copay per visit	Deductible and coinsurance
Specialist Office Visits		$40 copay per visit, No copay for unmarried dependent children and unmarried dependent students	Deductible and coinsurance
Annual Deductible (Individual/family)		$1,000/$3,000	$2,000/$6,000
Coinsurance		80%/20%	60%/40%
Annual Coinsurance Maximum (Individual/Family)		$3,000/$9,000	$6,000/$18,000
Inpatient Hospital Admission	PRECERTIFICATION: YES 365 days per confinement	Deductible and coinsurance	Deductible and coinsurance
Emergency Room Care Facility Copay	Waived if admitted	$100 Copay per visit	$100 copay per visit
Annual Maximum Benefit per Individual		Unlimited	$1,000,000
Lifetime Maximum		Unlimited	Unlimited
Unmarried Dependent Children/ Unmarried Dependent Students	Coverage effective until end of calendar year	Eligible to age 19/25	Eligible to age 19/25

INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL

	Comments	In-network	Out-of-network
Inpatient Hospital Admission	PRECERTIFICATION: YES 365 days per confinement	Deductible and coinsurance	Deductible and coinsurance
Skilled Nursing Facility Care	PRECERTIFICATION: YES	Deductible and coinsurance	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	Deductible and coinsurance
Hospice Care - Inpatient and Outpatient	PRECERTIFICATION: YES 210 days per lifetime	Deductible and coinsurance	Covered in-network only

OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY

	Comments	In-network	Out-of-network
Pre-Admission Testing		Deductible and coinsurance	Deductible and coinsurance
Ambulatory Surgery Facility Charge (free-standing)	PRECERTIFICATION: YES	Deductible and coinsurance	Deductible and coinsurance
Ambulatory Surgery Facility Charge (Outpatient hospital)	PRECERTIFICATION: YES	Deductible and coinsurance	Deductible and coinsurance
Home Health Care Services	PRECERTIFICATION: YES 200 visits per calendar year	20% Coinsurance (deductible waived)	20% Coinsurance (deductible waived)
Diagnostic Laboratory /Radiology	PRECERTIFICATION: YES Required for radiology (in-network services only)	Deductible and coinsurance	Deductible and coinsurance
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full	Deductible and coinsurance

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

	Comments	In-network	Out-of-network
WELL BABY AND CHILD CARE			
Well Baby and Well Child Care, Including Immunizations	Up to age 19	Covered in full	Deductible and coinsurance
EMERGENCY COVERAGE			
Emergency Room (ER) Care Facility Copay	ER copay, waived if admitted	ER facility copay	ER facility copay
Emergency Ground Ambulance		Not applicable	Covered up to 100% of usual and customary amount; subject to in-network deductible and coinsur-ance
INPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY			
Inpatient Mental Health	PRECERTIFICATION: YES 30 days per calendar year. No visit limits for biologically-based mental illness and children wth serious emotional disturbances	Deductible and coinsurance	Deductible and coinsurance
Chemical Dependency: Detoxification	PRECERTIFICATION: YES 7 days per calendar year	Deductible and coinsurance	Deductible and coinsurance
Chemical Dependency: Rehabilitation	PRECERTIFICATION: YES 30 days per calendar year	Deductible and coinsurance	Deductible and coinsurance
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	Deductible and coinsurance
Outpatient Mental Health	PRECERTIFICATION: YES (applies to in-network only services). 30 days per calendar year. No visit limits for biologically-based mental illness and children wth serious emotional disturbances	$40 copay per visit; No copay for unmarried dependent chil-dren and unmarried dependent students	Deductible and coinsurance
VISION			
Exam	Performed by Davis Vision provid-ers only; One eye exam every 24 months	$10 office visit copay adults; no copay for dependent children and unmarried dependent students	Covered through Davis Vision providers only
Frames, Lenses, Contacts	Eligibility: Children under the age of 19 - One eye exam every 24 months	Lenses, frames, contacts (in lieu of frames and lenses) $20 copay	Covered through Davis Vision providers only

The EmblemHealth InBalance PPO is underwritten by Group Health Incorporated ("GHI"). Coverage is subject to all terms, conditions, limitations and exclusions set forth in the contract and certificate of insurance. Refer to policy form number PLH-SGC-991, et.al. For out-of-network services, you are responsible to pay any difference between the plan's pay-ment and the provider's charge.

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.

EmblemHealth Prescription Drug Options

EmblemHealth PPO and InBalance PPO

Option CC	
Annual deductible per individual.*	$50
Retail copayment for generic/preferred brand name/ nonpreferred brand name drugs.	$0/$25/$50
Annual retail maximum per individual (no maximum on home delivery).	$3,000
Home delivery copayment for generic/preferred brand name/ nonpreferred brand name drugs.	$0/$50/$100

- Covered at EmblemHealth participating pharmacies only.
- Generic drugs are not mandatory. Other than the applicable copayment, no additional costs apply.
- All prescription drug options include clinical prior authorization and specialty pharmacy programs.

All services and benefits are subject to the specific terms and conditions of your Certificate of Insurance and Certificate Attachment and/or riders.

For more information, contact your EmblemHealth Sales Representative.

*Deductible applies to brand preferred and brand non-preferred drugs only.

Policy form # PLA-100B

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.