LIA Health Alliance
New York's Health Insurance Exchange

PPO 30/1000A

NATIONAL NETWORK

Benefit Summary EmblemHealth PPO $30/$500/$1,000/70%

BENEFIT HIGHLIGHTS

	Comments	In-network	Out-of-network
Office Visits and Diagnostic Services for Dependent Children/Students		$0 Copay per visit	Deductible and coinsurance
Office Visit, Including Outpatient Clinic Visits		$30 Copay per visit	Deductible and coinsurance
Emergency Room Care Facility Copay		$100 Copay (waived if admitted)	$100 Copay (waived if admitted)
Ambulatory Surgery Facility Copay		$250 Copay per visit	Deductible and coinsurance
Coinsurance		N/A	70%/30%
Annual Deductible (Individual/Family)		N/A	$1,000/$3,000
Annual Maximum Benefit per Individual		Unlimited	$1,000,000
Annual Coinsurance Maximum (Individual/Family)		N/A	$3,000/$9,000
Lifetime Maximum		Unlimited	Unlimited
Unmarried Dependent Children/ Unmarried Dependent Student	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			
Inpatient Hospital Admission	PRECERTIFICATION: YES 365 days per confinement	$500 Copay per single confinement	Deductible and coinsurance
Skilled Nursing Facility (SNF) Care	PRECERTIFICATION: YES	Covered in full	Deductible and coinsurance
Inpatient Admission for Medical Rehabilitation (i.e. Physical Therapy, Physical Medicine and Rehabilitation)	PRECERTIFICATION: YES 30 days per calendar year	$500 Copay per single confinement	Deductible and coinsurance
Hospice Care - Inpatient and Outpatient	PRECERTIFICATION: YES 210 days per lifetime	Covered in full	Covered in-network only
OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY			
Pre-Admission Testing		Covered in full	Deductible and coinsurance
Ambulatory Surgery Facility Charge (free-standing and outpatient hospital)	PRECERTIFICATION: YES	$250 Copay per visit	Deductible and coinsurance
Home Health Care Services	PRECERTIFICATION: YES 200 visits per calendar year	Covered in full	Deductible and coinsurance
Diagnostic Laboratory /Radiology	PRECERTIFICATION: YES Required for in-network radiology services	$30 Diagnostic copay; No copay for unmarried dependent children and unmarried dependent students	Deductible and coinsurance
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full	Deductible and coinsurance
MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN OR OTHER MEDICAL PROVIDER			
Office Visits and Diagnostic Services for Dependent Child(ren) /Student(s)		No copay for unmarried dependent children and unmarried dependent students.	Deductible and coinsurance
Office Visit, Including Outpatient Clinic Visits		$30 Copay per visit	Deductible and coinsurance
Specialist Office Visits		$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students	Deductible and coinsurance

	Comments	In-network	Out-of-network
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		$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students	Deductible and coinsurance
Allergy Care		$30 Copay 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	$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students	Deductible and coinsurance
Speech Therapy	10 Visits per calendar year	$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students	Deductible and coinsurance
Outpatient Surgery	Office	Covered in full	Deductible and coinsurance
	Outpatient hospital	Covered in full	Deductible and coinsurance
	Ambulatory free-standing	Covered in full	Deductible and coinsurance
Inpatient Surgery		Covered in full	Deductible and coinsurance
Durable Medical Equipment (DME)	PRECERTIFICATION: YES when amount >$2,000; $10,000 calendar year maximum	Covered in full, up to calendar year max	Covered in-network only
Diabetic Management: Education		$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students	Deductible and coinsurance
Prescriptions		$5 Adult, No copay for unmarried dependent children and unmarried dependent 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	$30 Diagnostic 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)	$30 Diagnostic copay per visit; No copay for unmarried dependent children and unmarried dependent students	Deductible and coinsurance

WELL BABY AND CHILD CARE

Well baby and Well Child Care, including Immunizations	Up to age 19	Covered in full	Deductible and coinsurance

EMERGENCY ROOM COVERAGE

Emergency Room (ER) Care Facility Copay	$100 ER copay per confinement, waived if admitted	$100 ER copay per confinement	$100 ER copay per confinement
Emergency Ground Ambulance		N/A	Covered up to 100% of usual and customary amount; deductible and coinsurance waived

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 with serious emotional disturbances	$500 Copay per single confinement	Deductible and coinsurance

	Comments	In-network	Out-of-network
Chemical Dependency: Detoxification	PRECERTIFICATION: YES 7 days per calendar year	$500 Copay per single confinement	Deductible and coinsurance
Chemical Dependency: Rehabilitation	PRECERTIFICATION: YES 30 days per calendar year	$500 Copay per single confinement	Deductible and coinsurance

OUTPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

	Comments	In-network	Out-of-network
Outpatient Chemical Dependency	PRECERTIFICATION: YES 60 visits per calendar year	Covered in full	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 with serious emotional disturbances	$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students	Deductible and coinsurance

VISION

	Comments	In-network	Out-of-network
Exam	Performed by Davis Vision providers only; One eye exam every 24 months	$10 Office visit copay adults; no copay for dependent children and unmarried dependent students	Performed by 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	Performed by Davis Vision providers only

The EmblemHealth 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-976-2, et.al. For out-of-network services, you are responsible to pay any difference between the plan's payment 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.