

LIA HEALTH ALLIANCE

HIP HMO 10 (open access) with Vytra Premium Network

Please read Insurer Descriptions and Focus Provider Directories before making benefit plan selections.

BENEFIT CHOICES	IN NETWORK
<u>FINANCIAL</u>	
Network Copay	\$10 copay
Annual Deductible Out of Network (Individual/Family)	
Out of Network Coinsurance/Coinsurance Max	NA
Out of Pocket Maximum	NA
Annual Deductible In-Network (Individual/Family)	
In-Network Coinsurance/Coinsurance Max	NA
Out of Pocket Maximum	NA
Lifetime Maximum Benefit	NA
Max.Age for Dependent Children/Full-time Students	19/25
<u>PRESCRIPTION DRUG CARD BENEFITS</u>	
Generic/Name Brand/Non-formulary	\$10/\$20/\$50
<u>ADULT & CHILDREN'S PREVENTIVE CARE</u>	
Preventative: Well Baby, Well Child, Immunizations, Mammograms, Pap Tests, Annual Physical Exam	Covered in full Included in PCP copay
<u>Care Rendered Outside a Hospital Setting</u>	
Primary Physician Office Visits	\$10 copay
Specialist Office Visits	\$10 copay
Laboratory Services	Included in PCP copay
Radiology	Included in PCP copay
<u>HOSPITAL CARE</u>	
Inpatient Facility Services	Inpatient: No copay
Out Patient Facility Service (Ambulatory Surgery)	Ambulatory Surgery: No copay
In-Patient Physician and Surgeon Services	
Out-Patient Physician and Surgeon Services	
Semi-Private Room and Board	
All Drugs and Medications	
<u>EMERGENCY CARE</u>	
Emergency Room Copay	\$35 copay per visit
Emergency Room Professional Services	NA
Ambulance Services when necessary	Covered in full
<u>MATERNITY CARE</u>	
Prenatal and Post-Natal Care	Covered in full (in physician's office)
Hospital Service	No copay
<u>MENTAL HEALTH CARE</u>	
Outpatient Visits	\$25 copay; 20 visits per calendar year
Inpatient Care	No copay; 30 days per calendar year
<u>SUBSTANCE ABUSE</u>	
Inpatient Detox.	No copay; 21 days per calendar year
Inpatient Rehab. per calendar year -60 days lifetime	Not covered
Outpatient Visits	\$10 copay per visit; 60 visit limit per calendar year
<u>ALTERNATIVE CARE SERVICES</u>	
Skilled Nursing Facility	\$0 copay; 45 days per calendar year
Home Health Care	No copay; 40 visits per calendar year
Hospice	Covered in full; 210 days
<u>SHORT-TERM THERAPY</u>	
Physical Therapy, Occupational	Outpatient: \$10 copay; 120 visits per calendar year
Speech Therapy	Inpatient: no copay; 30 days per calendar year
<u>CHIROPRACTIC CARE</u>	
<u>DURABLE MED. EQUIPMENT/PROSTHETICS</u>	
<u>VISION</u>	Eye Exam \$10 copay Eyeglasses; \$45 for complete pair/24 months
<u>DENTAL</u>	Reduced member fee schedule

NOTE: This is a brief summary of benefits and should only be used as a guide. You must refer to the selected insurer's subscriber agreement for a complete description of requirements for coverage, covered services, limitations and exclusions.