

# LIA HEALTH ALLIANCE

## HIP HMO 15 (open access) with Vytra Premium Network

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

BENEFIT CHOICES	IN NETWORK
<b><u>FINANCIAL</u></b>	
Network Copay	\$15 copay
<b>Annual Deductible Out of Network (Individual/Family)</b>	
Out of Network Coinsurance/Coinsurance Max	NA
Out of Pocket Maximum	NA
<b>Annual Deductible In-Network (Individual/Family)</b>	
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
<b><u>PRESCRIPTION DRUG CARD BENEFITS</u></b>	
Generic/Name Brand/Non-formulary	\$10/\$20/\$50
<b><u>ADULT &amp; CHILDREN'S PREVENTIVE CARE</u></b>	
Preventative: Well Baby, Well Child, Immunizations, Mammograms, Pap Tests, Annual Physical Exam	Covered in full Included in PCP copay
<b><u>Care Rendered Outside a Hospital Setting</u></b>	
Primary Physician Office Visits	\$15 copay
Specialist Office Visits	\$15 copay
Laboratory Services	Included in PCP copay
Radiology	Included in PCP copay
<b><u>HOSPITAL CARE</u></b>	
Inpatient Facility Services	Inpatient: \$250 copay per Hospital Admission
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	
<b><u>EMERGENCY CARE</u></b>	
Emergency Room Copay	\$35 copay per visit
Emergency Room Professional Services	NA
Ambulance Services when necessary	Covered in full
<b><u>MATERNITY CARE</u></b>	
Prenatal and Post-Natal Care	Covered in full (in physician's office)
Hospital Service	\$250 copay per Hospital Admission
<b><u>MENTAL HEALTH CARE</u></b>	
Outpatient Visits	\$25 copay; 20 visits per calendar year
Inpatient Care	\$250 copay per admission; 30 days per calendar year
<b><u>SUBSTANCE ABUSE</u></b>	
Inpatient Detox.	\$250 copay per admission; 21 days per calendar year
Inpatient Rehab. per calendar year -60 days lifetime	Not covered
Outpatient Visits	\$15 copay per visit; 60 visit limit per calendar year
<b><u>ALTERNATIVE CARE SERVICES</u></b>	
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
<b><u>SHORT-TERM THERAPY</u></b>	
Physical Therapy, Occupational	Outpatient: \$15 copay; 120 visits per calendar year
Speech Therapy	Inpatient: Included in hospital copay; 30 days per calendar year
<b><u>CHIROPRACTIC CARE</u></b>	
<b><u>DURABLE MED. EQUIPMENT/PROSTHETICS</u></b>	
<b><u>VISION</u></b>	\$0 annual deductible Eye Exam \$15 copay Eyeglasses; \$45 for complete pair/24 months
<b><u>DENTAL</u></b>	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.