

# LIA HEALTH ALLIANCE

## HIP POS 15/500 with Vytra Premium Network

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

BENEFIT CHOICES	IN NETWORK	OUT OF NETWORK
<b>FINANCIAL</b>		
Network Copay	\$15 copay	NA
<b>Annual Deductible Out of Network (Individual/Family)</b>	NA	\$500/\$1000
Out of Network Coinsurance/Coinsurance Max	NA	70%/30% \$2000/\$4000
Out of Pocket Maximum	NA	NA
<b>Annual Deductible In-Network (Individual/Family)</b>	NA	NA
In-Network Coinsurance/Coinsurance Max	NA	NA
Out of Pocket Maximum	NA	NA
Lifetime Maximum Benefit	Unlimited	\$5,000,000 per member
Max.Age for Dependent Children/Full-time Students	19/25	19/25
<b>PRESCRIPTION DRUG CARD BENEFITS</b>		
Generic/Name Brand/Non-formulary	\$7/\$15/\$35	NA
<b>ADULT &amp; CHILDREN'S PREVENTIVE CARE</b>		
Preventative: Well Baby, Well Child, Immunizations Mammograms, Pap Tests, Annual Physical Exam	\$0 copay Included in PCP copay	Covered 70% after deductible Covered 70% after deductible Annual Physical - not covered
<b>Care Rendered Outside a Hospital Setting</b>		
Primary Physician Office Visits Specialist Office Visits Laboratory Services Radiology	\$15 copay \$15 copay Included in PCP copay Included in PCP copay	Covered 70% after deductible Covered 70% after deductible (Covered 70% after deductible when related to illness or injury)
<b>HOSPITAL CARE</b>		
Inpatient Facility Services Out Patient Facility Service (Ambulatory Surgery) In-Patient Physician and Surgeon Services Out-Patient Physician and Surgeon Services Semi-Private Room and Board All Drugs and Medications	Inpatient: No copay Ambulatory Surgery: No copay	Covered 70% after deductible Covered 70% after deductible
<b>EMERGENCY CARE</b>		
Emergency Room Copay Emergency Room Professional Services Ambulance Services when necessary	\$50 copay per visit NA \$0 copay	NA NA Covered 70% after deductible
<b>MATERNITY CARE</b>		
Prenatal and Post-Natal Care Hospital Service	\$0 copay No copay	Covered 70% after deductible Covered 70% after deductible
<b>MENTAL HEALTH CARE</b>		
Outpatient Visits Inpatient Care	\$25 copay; 20 visits per calendar year No copay; 30 days per calendar year	Covered 50% after deductible Covered 70% after deductible
<b>SUBSTANCE ABUSE</b>		
Inpatient Detox. Inpatient Rehab. Outpatient Visits	No copay; 7 days per calendar year No copay; 30 days per calendar year \$15 copay 60 visits per calendar year	Covered 70% after deductible Not covered Covered 70% after deductible
<b>ALTERNATIVE CARE SERVICES</b>		
Skilled Nursing Facility Home Health Care Hospice	\$0 copay; 90 days per calendar year \$15 copay; 40 visits per calendar year \$0 copay; 210 days	Not covered Out-of-Network Covered 70% after deductible Not covered Out-of-Network
<b>SHORT-TERM THERAPY</b>		
Physical Therapy, Occupational Speech Therapy	Outpatient: \$15 copay; 120 visits per cal yr Inpatient: No copay; 30 days per cal yr	Covered 70% after deductible Covered 70% after deductible
<b>CHIROPRACTIC CARE</b>	\$15 copay	Covered 70% after deductible
<b>DURABLE MED. EQUIPMENT/PROSTHETICS</b>	\$0 annual deductible	Not covered Out-of-Network
<b>VISION</b>	Eye Exam: \$15 copay; Eyeglasses: \$45 for a complete pair every 24 months	Covered 70% after deductible Eyeglasses: Not covered Out-of-Network
<b>DENTAL</b>	Reduced member fee schedule	Not covered Out-of-Network

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.