

# Labor-Management Healthcare Coalition<sup>®</sup>

## PPO 6322 / High Deductible

### Summary of Benefits

<b>Deductibles/Maximums</b>	
In-network deductible	\$2,600/\$5,200
In-network co-insurance	N/A
Medical in-network out-of-pocket maximum	\$5,000/\$10,000
Pharmacy in-network out-of-pocket maximum	\$3,700/\$7,400
Out-of-network deductible	\$5,000/\$10,000
Out-of-network co-insurance	50% after deductible
Out-of-network out of pocket maximum	\$10,000/\$20,000
Annual maximum	Unlimited
Lifetime maximum	Unlimited
Benefit administration	Calendar year
Dependent age	26
Student age	26
Dependent/Student coverage ends	End of birth month
Domestic partner	No Coverage for domestic partner
<b>Prescription Drug</b>	
Prescription copay	\$5/\$30/\$50 after deductible
Mail order copay per 90-day supply	1 copay
Option 90 - 90 day supply at retail	2.5 copays
<b>Medical Services</b>	
Primary care physician copay	\$25 copay after deductible
Specialist copay	\$40 copay after deductible
Telemedicine	\$25 copay after deductible
Pediatric visits for children up to age 19	\$25 copay after deductible
Specialist copay/coinsurance for dependents up to age 19	\$40 copay after deductible
Allergy Injections/Testing	\$40 copay after deductible
Chiropractic care	\$25 copay/\$40 copay after deductible
Laboratory services	\$40 copay after deductible
Radiology (x-ray, MRI, CT & other high tech imaging)	\$25 copay/\$40 copay after deductible
Pre & post natal care	\$25 copay/\$40 copay after deductible
<b>Physician Services - Preventive</b>	
Abdominal aortic aneurysm screening	Covered in full
Adult immunizations (flu vaccinations covered in full)	Covered in full
Bone mineral density screening	Covered in full
Routine colorectal cancer screening	Covered in full
Routine mammogram	Covered in full
Routine OB/GYN	Covered in full
Routine pap smear	Covered in full
Routine physical exam	Covered in full
PSA test	Covered in full
Routine eye exam	Covered in full

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Hospital	
Inpatient hospital stay	\$500 copay after deductible
Inpatient maternity stay	\$500 copay after deductible
Outpatient surgery	\$150 copay after deductible
Emergency Hospital Care	
Emergency room (copay waived if admitted to hospital)	\$100 copayment after deductible
Ambulance - ground ambulance	\$75 copay after deductible
Ambulance - air ambulance	\$75 copay after deductible
Urgent care centers	\$50 copay after deductible
Mental Health & Substance Abuse	
Inpatient mental health	\$500 copay after deductible
Outpatient mental health	\$25 copay after deductible
Inpatient alcohol & substance abuse detoxification	\$500 copay after deductible
Inpatient alcohol & substance abuse rehabilitation	\$500 copay after deductible
Outpatient alcohol & substance abuse	\$25 copay after deductible
Other Services	
Chemotherapy - Outpatient Facility	\$40 copay after deductible
Dialysis	\$40 copay after deductible
Durable medical equipment	Covered if full after deductible
Home care, 200 visits IN & OON	\$25 copay/\$40 copay after deductible
Hospice, 210 days per plan year aggregate INN & OON	\$25 copay/\$40 copay after deductible
Pulmonary Rehab	\$25 copay/\$40 copay after deductible
Physical, speech & occupational therapy, 60 visits, aggregate IN & OON, with PT/OT/ST, per plan year	\$25 copay/\$40 copay after deductible
Prosthetic and orthotic appliances	20% coinsurance after deductible
Skilled nursing facility (Not long Term Care-Rehab only)	\$500 copay after deductible, unlimited days

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*\*\*This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.*