Labor-Management Healthcare Coalition ™

Enhanced Plan

Summary of Benefits

POS 202

Deductibles/Maximums	
In-network deductible	N/A
In-network co-insurance	N/A
Medical in-network out-of-pocket maximum	$5,125/$10,250
Pharmacy in-network out-of-pocket maximum	$1,725/$3,450
Out-of-network deductible	$300/$600
Out-of-network co-insurance	20%
Out-of-network out of pocket maximum	$2,000/$4,000
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
Prescription Drug	
Prescription copay	$0/$7/$10
Mail order copay per 90-day supply	1 copay
Option 90 - 90 day supply at retail	2.5 copays
Medical Services	
Primary care physician copay	$8
Specialist copay	$8
Pediatric visits for children up to age 19	$8
Well child visits and immunizations for children up to age 19	Covered in full
Allergy immunotherapy	$8
Chiropractic care	$8
Chiropractic care - 8 maintenance visits	$8
Laboratory services	Covered in full
Radiology (x-ray, MRI, CT & other high tech imaging)	$8
Pre & post natal care	Covered in full after intial $8 copay
Physician Services - Preventive	
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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POS 202

Hospital	
Inpatient hospital stay	Covered in full
Inpatient maternity stay	Covered in full
Outpatient surgery	$8
Emergency Hospital Care	
Emergency room (copay waived if admitted to hospital)	$35
Ambulance - ground ambulance	$35
Ambulance - air ambulance	$35
Urgent care centers	$8
Mental Health & Substance Abuse	
Inpatient mental health	Covered in full
Outpatient mental health	$8
Inpatient alcohol & substance abuse detoxification	Covered in full
Inpatient alcohol & substance abuse rehabilitation	Covered in full
Outpatient alcohol & substance abuse	$8
Other Services	
Cardiac rehabilitation (24 visits within 12 weeks of acute episode)	$8
Chemotherapy	$8
Dialysis	$8
Durable medical equipment	20% co-insurance
Home care	Unlimited visits, Covered in full
Hospice	Covered in full
Acupuncture (6 visits per calendar year)	$8
Massage (12 visits per calendar year)	$8
Routine podiatry care	$8
Physical, speech & occupational therapy	30 visits per therapy, $8
Prosthetic and orthotic appliances	20% co-insurance
Radiation therapy	$8
Skilled nursing facility (Not Long Term Care-Rehab only)	Unlimited days, Covered in full

revised 1/1/2016 *(00999194, 00400674, 00402041, 00402531, 00400051, 00403439, 00403440/0003)*

***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.*