Labor-Management Healthcare Coalition ™

Value Plan - PBA

Summary of Benefits

POS 204

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	$1,000/$2,000
Out-of-network co-insurance	25%
Out-of-network out of pocket maximum	$2,500/$5,000
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	$10/$15/$20
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	$15
Specialist copay	$15
Pediatric visits for children up to age 19	$15
Well child visits and immunizations for children up to age 19	Covered in full
Allergy immunotherapy	$15
Chiropractic	$15
Laboratory services	Covered in full
Radiology (x-ray, MRI, CT & other high tech imaging)	$15
Pre & post natal care	Covered in full after intial $15 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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Summary of Benefits

POS 204

Hospital	
Inpatient hospital stay	$250 deductible
Inpatient maternity stay	$250 deductible
Outpatient surgery	$15
Emergency Hospital Care	
Emergency room (copay waived if admitted to hospital)	$100
Ambulance - ground ambulance	$100
Ambulance - air ambulance	$100
Urgent care centers	$15
Mental Health & Substance Abuse	
Inpatient mental health	$250 deductible *
Outpatient mental health	$15
Inpatient alcohol & substance abuse detoxification	$250 deductible *
Inpatient alcohol & substance abuse rehabilitation	$250 deductible *
Outpatient alcohol & substance abuse	$15
Other Services	
Cardiac rehabilitation (24 visits within 12 weeks of acute episode)	$15
Chemotherapy	$15
Dialysis	$15
Durable medical equipment	50% co-insurance
Home care	Unlimited visits, Covered in full
Hospice	Covered in full
Accupuncture (6 visits per calendar year)	Not Available
Massage (12 visits per calendar year)	Not Available
Routine podiatry care	$15
Physical, speech & occupational therapy	30 visits per therapy, $15
Prosthetic and orthotic appliances	50% co-insurance
Radiation therapy	$15
Skilled nursing facility (Not Long Term Care-Rehab only)	Unlimited days, Covered in full

revised 1/1/2016 (00999194, 0005/0009)

** deductible applies per person, up to a $500 maximum per family per year*

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.