Labor-Management Healthcare Coalition®

Lewiston-Porter Schools

Summary of Benefits

POS 200 $0/$0 - Plan A

Deductibles/Maximums	
In-network deductible	N/A
In-network co-insurance	N/A
Medical in-network out-of-pocket maximum	$4,000/$8,000
Pharmacy in-network out-of-pocket maximum	$1,000/$2,000
Out-of-network deductible	$1,000/$2,000
Out-of-network co-insurance	25% after deductible
Out-of-network out of pocket maximum	$5,000/$10,000
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	Includes coverage for domestic partner and children
Prescription Drug	
Prescription copay	$0/$15/$30
Mail order copay per 90-day supply	1 copay
Option 90 - 90 day supply at retail	2.5 copays
Office/Urgent Care Visits	
Primary care physician office visits & virtual visits	Covered in full
Specialist office visits & virtual visits	Covered in full
Virtual visit provider originating site fee	Covered in full
Urgent care center visits	Covered in full
Telemedicine	Covered in full
Preventative Care	
Routine adult physical exam	Covered in full
Adult immunizations	Covered in full
Routine OB/GYN exam including a pap test	Covered in full
Mammograms, annual routine	Covered in full
Mammograms, medically necessary	Covered in full
Diagnostic services & procedures	Covered in full
Routine Pediatric physical exams	Covered in full
Routine Pediatric immunizations	Covered in full
Routine Pediatric diagnostic & services & procedures	Covered in full
Emergency Services	
Emergency room services	$50 copay (waived if admitted)
Ambulance - Emergency & Non-Emergency	$25 copay
Hospital & Medical / Surgical Expenses (including maternity)	
Hospital inpatient	Covered in full
Outpatient surgery	Covered in full
Maternity (non-preventative professional services) including dependent daughter)	Covered in full
Medical Care (including inpatient visits & consultations)	Covered in full

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Therapy & Rehabilitation Services	
Physical therapy (30 visits/benefit period aggregate with OT & Speech)	Covered in full
Speech therapy (30 visits/benefit period aggregate with OT & PT)	Covered in full
Occupational therapy (30 visits/benefit period aggregate with Speech & PT)	Covered in full
Respiratory therapy (limit 24 visits within in a 12 week period for pulmonary rehab)	Covered in full
Spinal manipulations	Covered in full
Cardiac rehabilitation (24 visits per plan year in a 12 week period/aggregate IN & OON)	Covered in full
Infusion therapy	Covered in full
Chemotherapy	Covered in full
Radiation therapy	Covered in full
Dialysis	Covered in full
Mental Health & Substance Abuse	
Inpatient mental health	Covered in full
Inpatient detoxification/rehabiliatation	Covered in full
Outpatient mental health services (includes virtual behavioral health visits)	Covered in full
Outpatient substance abuse services	Covered in full
Other Services	
Allergy extracts & injections	Covered in full
Advanced imaging (MRI, CAT, PET scan etc.)	Covered in full
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	Covered in full
Durable medical equipment & supplies	50%
Orthotics	50%
Prosthetic devices	Covered in full, 50% for external prosthetics
Home health care	Covered in full
Hospice (210 days/benefit period)	Covered in full
Skilled nursing facility care	Covered in full
Transplant service	Covered in full

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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.*