

Labor-Management Healthcare Coalition®

Lewiston-Porter Schools

Summary of Benefits

POS 200 \$5/\$10 - Plan B

Deductibles/Maximums	
In-network deductible	N/A
In-network co-insurance	N/A
Medical in-network out-of-pocket maximum	\$4,750/\$9,500
Pharmacy in-network out-of-pocket maximum	\$1,600/\$3,200
Out-of-network deductible	\$1,500/\$3,000
Out-of-network co-insurance	25% 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	Includes coverage for domestic partner and children
Prescription Drug	
Prescription copay	\$5/\$15/\$35
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	\$5 copay
Specialist office visits & virtual visits	\$10 copay
Virtual visit provider originating site fee	\$10 copay
Urgent care center visits	\$25 copay
Telemedicine	\$5 copay
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	\$10 copay for specialist; \$5 copay for pcp
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	\$150 copay (waived if admitted); \$25 copay for freestanding urgent care facility
Ambulance - Emergency & Non-Emergency	\$50 copay

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Hospital & Medical / Surgical Expenses (including maternity)	
Hospital inpatient	Covered in full
Outpatient surgery	\$75 copay
Maternity (non-preventative professional services) including dependent daughter)	\$5 copay (copay on initial visit only)
Medical Care (including inpatient visits & consultations)	Covered in full
Therapy & Rehabilitation services	
Physical therapy (30 visits/benefit period aggregate with OT & Speech)	\$10 copay
Speech therapy (30 visits/benefit period aggregate with OT & PT)	\$10 copay
Occupational therapy (30 visits/benefit period aggregate with Speech & PT)	\$10 copay
Respiratory therapy (24 visits/benefit period for pulmonary rehab)	\$10 copay
Spinal manipulations	\$10 copay for specialist/\$5 for pcp
Cardiac rehabilitation (24 visits/benefit period within 12 week period)	\$10 copay
Infusion therapy	\$10 copay
Chemotherapy	\$10 copay
Radiation therapy	\$10 copay for specialist/\$5 for pcp
Dialysis	Covered in full
Mental Health & Substance Abuse	
Inpatient mental health	Covered in full
Inpatient detoxification/rehabilitation	Covered in full
Outpatient mental health services (includes virtual behavioral health visits)	\$5 copay
Outpatient substance abuse services	\$5 copay
Other Services	
Allergy testing & injections	\$10 copay for specialist/\$5 for pcp
Allergy extracts	Covered in full
Advanced imaging (MRI, CAT, PET scan etc.)	\$10 copay for specialist/\$5 for pcp
Standard imaging	\$10 copay for specialist/\$5 for pcp
Diagnostic medical	\$10 copay for specialist/\$5 for pcp; \$10 copay sleep studies
Laboratory/Pathology	Covered in full
Durable medical equipment & supplies	20%, \$5 copay for diabetic supplies & equipment
Orthotics	20%
Prosthetic devices	covered in full, 20% for external prosthetics
Home health care	\$10 copay
Hospice (limit 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.*