

**Labor-Management Healthcare Coalition®**

**Lewiston-Porter Schools**

**Summary of Benefits**

**POS 7200 \$0/\$0 HDHP**

Deductibles/Maximums	
In-network deductible (combined with out-of-network deductible)	\$1,600/\$3,200
In-network co-insurance	0% after deductible
In-network out-of-pocket maximum	\$5,000/\$10,000
Out-of-network deductible (combined with in-network deductible)	\$1,600/\$3,200
Out-of-network co-insurance	20% 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	\$0/\$30/\$50 after in-network deductible
Mail order copay per 90-day supply	2 copays
Office/Urgent Care Visits	
Primary care physician office visits & virtual visits	0% after deductible
Specialist office visits & virtual visits	0% after deductible
Virtual visit provider originating site fee	0% after deductible
Urgent care center visits	0% after deductible
Telemedicine services	0% after deductible
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	0% after deductible
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	0% after deductible
Ambulance - Emergency & Non-Emergency	0% after deductible
Hospital & Medical / Surgical Expenses (including maternity)	
Hospital inpatient	\$250 inpatient copay/admission after deductible
Outpatient surgery	0% after deductible
Maternity (non-preventative professional services) including dependent daughter)	0% after deductible
Medical Care (including inpatient visits & consultations)	0% after deductible

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Therapy & Rehabilitation services	
Physical therapy (60 visits/benefit period aggregate with OT & Speech)	0% after deductible
Speech therapy (60 visits/benefit period aggregate with OT & PT)	0% after deductible
Occupational therapy (60 visits/benefit period aggregate with Speech & PT)	0% after deductible
Respiratory therapy (24 visits/benefit period for pulmonary rehab)	0% after deductible
Spinal manipulations	0% after deductible
Cardiac rehabilitation therapy (24 visits/benefit period)	0% after deductible
Infusion therapy	0% after deductible
Chemotherapy	0% after deductible
Radiation therapy	0% after deductible
Dialysis	0% after deductible
Mental Health & Substance Abuse	
Inpatient mental health	\$250 inpatient copay/admission after deductible
Inpatient detoxification/rehabilitation	\$250 inpatient copay/admission after deductible
Outpatient mental health services (includes virtual behavioral health visits)	0% after deductible
Outpatient substance abuse services	0% after deductible
Other Services	
Allergy extracts & injections	0% after deductible
Advanced imaging (MRI, CAT, PET scan etc.)	0% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	0% after deductible
Durable medical equipment, Orthotics, & Prosthetics	0% after deductible
Home health care (100 visits/benefit period aggregate with visiting nurse)	0% after deductible
Hospice	0% after deductible
Skilled nursing facility care	\$250 inpatient copay/admission after deductible
Transplant service	\$250 inpatient copay/admission after deductible

created 5/30/2024

*\*\*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.*