

Labor-Management Healthcare Coalition[®]

Value Plan 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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| Hospital | |
|---|-----------------------------------|
| Inpatient hospital stay | \$300 deductible |
| Inpatient maternity stay | \$300 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 | \$300 deductible |
| Outpatient mental health | \$15 |
| Inpatient alcohol & substance abuse detoxification | \$300 deductible |
| Inpatient alcohol & substance abuse rehabilitation | \$300 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 |
| Routine podiatry care | \$15 |
| Physical, speech & occupational therapy | 20 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 1/1/2018

***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.*