Labor-Management Healthcare Coalition®

Pioneer School District

Summary of Benefits

PPO 835

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	30% 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
Medical Services	
Primary care physician copay	Covered in full
Specialist copay	Covered in full
Telemedicine	Covered in full
Pediatric visits for children up to age 19	Covered in full
Well child visits and immunizations for children up to age 19	Covered in full
Allergy testing & injections	Covered in full
Chiropractic	Covered in full
Laboratory services	Covered in full
Radiology	Covered in full
Pre & post natal care initial visit	Covered in full
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
Cholesterol test (lipid panel)	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	Covered in full
Inpatient maternity stay	Covered in full
Outpatient surgery	Covered in full
Emergency Hospital Care	
Emergency room (copay waived if admitted to hospital)	$50 copay
Ambulance - ground ambulance	$25 copay
Ambulance - air ambulance	$25 copay
Urgent care centers	Covered in full
Mental Health & Substance Abuse	
Inpatient mental health	Covered in full
Outpatient mental health	Covered in full
Inpatient alcohol & substance abuse detoxification	Covered in full
Inpatient alcohol & substance abuse rehabilitation	Covered in full
Outpatient alcohol & substance abuse	Covered in full
Diabetic Supplies and Services	
Diabetic Equipment	Covered in full
Diabetic Medical Supplies (test strips, syringes, etc,)	Covered in full
Other Services	
Cardiac rehabilitation	Covered in full
Pulmonary Rehababilition	Covered in full
Chemotherapy	Covered in full
Dialysis	Covered in full
Durable medical equipment	50% co-insurance
Home care	Covered in full
Hospice	Covered in full
Acupuncture (6 visits per calendar year)	Covered in full
Massage therapy (12 visits per calendar year)	Covered in full
Physical, speech & occupational therapy (30 visits per calendar year)	Covered in full
Prosthetic and orthotic appliances	50% co-insurance
Radiation therapy	Covered in full
Skilled nursing facility (Not long Term Care-Rehab only)	Covered in full

created 1/1/2025

***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.*