



LCHP PPO Plan Description of Coverage (LGHP)

| | | In Network | Out of Network |
|--|---|--|--|
| Basic Care (See Provider Directory to select an in-network provider) | | | |
| Plan-year deductible | | \$750 per benefit participant | |
| Plan-year and lifetime maximums | | Unlimited | |
| Out-of-pocket maximums | | Individual Family | \$1,750 \$3,500 |
| | | | \$4,750 \$9,500 |
| Description of Coverage | | | |
| Hospital | | | |
| Number of days of inpatient care | Unlimited when authorized | \$250 ded. per hospital admission 90% after the annual plan ded. | \$500 ded. per hospital admission 60% of allowable charges after the annual plan ded. |
| Room and board | Semi-private room, intensive care | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Surgeon's fees | Inpatient or outpatient | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Provider's visit | | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Medications | | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Other miscellaneous charges | Except personal comfort items | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Emergency | | | |
| Emergency services (medical conditions of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part) | Copay waived if admitted as an inpatient for same condition within 48 hours | \$400 deductible 90% after the annual plan ded. | \$400 deductible 90% after the annual plan ded. |
| Provider's Office | | | |
| Provider's office visits | Exam, diagnosis, treatment | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Preventive care | ACA guidelines apply | 100% coverage | 60% of allowable charges after the annual plan ded. |
| Diagnostic tests and X-rays | May require authorization | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Immunizations | | 100% coverage | 60% of allowable charges after the annual plan ded. |
| Allergy treatment and testing | | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Medical Services | | | |
| Outpatient surgery | Surgery and observation; may require authorization | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Maternity care | Hospital care | Room and board, ancillary services, care of child during mother's stay | \$250 deductible per admission 90% after the annual plan ded. |
| | Provider care | Prenatal, delivery and post-natal care | \$500 deductible per admission 60% of allowable charges after the annual plan ded. |
| Infertility services | See benefits certificate for details on coverage | | |
| Mental health treatment | | Administered through the state self-insured behavioral health benefits manager | |
| Substance abuse treatment | | Administered through the state self-insured behavioral health benefits manager | |
| Outpatient rehabilitation services | 60-day treatment period per condition | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Speech therapy – Pervasive developmental disorders | 20 visits per contract year | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Other Services | | | |
| Durable medical equipment | Prosthetic devices included | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Hospice | | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Home health care | | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Skilled nursing facility | When authorized | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Ambulance | When medically necessary | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Chiropractic services | 30 visits per plan year | 90% after the annual plan ded. | 60% of allowable charges after the annual plan ded. |
| Organ transplants | Out-of-pocket maximum applies when authorized | 90% after the \$250 transplant ded. | Not covered |
| Prescription drugs | | Administered through the state self-insured prescription benefits manager | |
| Dental services | Not covered | n/a | n/a |
| Vision care | Not covered | n/a | n/a |

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TTY: 711

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