

Open Access Plan Description of Coverage (LGHP)

		Tier 1	Tier 2*	Tier 3**,**
Basic Care (See Provider Directory to select an in-network provider)				
Annual deductible		None	\$300 per enrollee	\$500 per enrollee
Out-of-pocket maximum				
Tier 1 and Tier 2 cross accumulate. Includes Tier 2 deductible, Tier 1 and Tier 2 copayments/coinsurance.	Individual Family	\$6,250 \$12,700	\$6,250 \$12,700	Not applicable Not applicable
Lifetime maximum		Unlimited	Unlimited	Unlimited
Pre-existing condition limitations		None	None	None
Description of Coverage				
Hospital				
Number of days of inpatient care	Unlimited when authorized	\$250 copay per admission	10% coinsurance after \$300 copay	20% coinsurance of MAC after \$400 copay
Room and board	Semi-private room, intensive care		10% coinsurance	20% coinsurance of MAC
Surgeon's fees	Inpatient or outpatient	\$0 copay	10% coinsurance	40% coinsurance of MAC
Provider's visit		\$0 copay	10% coinsurance	20% coinsurance of MAC
Medications		\$0 copay	10% coinsurance	20% coinsurance of MAC
Other miscellaneous charges	Except personal comfort items	\$0 copay	10% coinsurance	20% coinsurance of MAC
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	\$200 copay	\$200 copay	\$200 copay
Emergency post-stabilization services	Copayment dependent on nature of service			
Provider's Office				
Provider's office visits	Exam, diagnosis, treatment	\$30 copay per office visit	10% coinsurance	20% coinsurance of MAC
Preventive care	ACA guidelines apply	100% coverage	100% coverage	Covered under Tier 1 and Tier 2 only
Diagnostic tests and X-rays	May require authorization	\$0 copay	10% coinsurance	20% coinsurance of MAC
Immunizations		\$0 copay	100% coverage	Covered under Tier 1 and Tier 2 only
Allergy treatment and testing		\$0 copay	100% coverage	Covered under Tier 1 and Tier 2 only
Medical Services				
Outpatient surgery	Surgery and observation; may require authorization	\$200 copay	10% coinsurance after \$200 copay	20% coinsurance of MAC after \$200 copay
Maternity care				
	Hospital care	Room and board, ancillary services, care of child during mother's stay	\$250 copay per admission	10% coinsurance after \$300 copay
	Provider care	Prenatal, delivery and post-natal care	\$0 copay	20% coinsurance
Infertility services	See benefits certificate for details on coverage		10% coinsurance	20% coinsurance of MAC
Mental health treatment				
	Inpatient		\$250 copay per admission	10% coinsurance after \$300 copay
	Outpatient		\$30 copay per office visit	10% coinsurance
Substance abuse treatment				
	Inpatient		\$250 copay per admission	10% coinsurance after \$300 copay
	Outpatient		\$30 copay per office visit	10% coinsurance
Outpatient rehabilitation services	Up to 60-day treatment period per condition	\$30 copay per office visit	10% coinsurance	Covered under Tier 1 and Tier 2 only
Speech therapy – Pervasive developmental disorders	20 visits per contract year	\$30 copay per office visit	10% coinsurance	Covered under Tier 1 and Tier 2 only
Other Services				
Durable medical equipment	Prosthetic devices included	20% coinsurance	20% coinsurance	20% coinsurance of MAC
Hospice		\$0 copay	10% coinsurance	20% coinsurance of MAC
Home health care		\$30 copay per visit	20% coinsurance	Covered under Tier 1 and Tier 2 only
Prescription drugs		Administered through the state self-insured prescription benefits manager		
Dental services	Not covered	n/a	n/a	n/a
Vision care	Not covered	n/a	n/a	n/a
Skilled nursing facility	When authorized	20% coinsurance	20% coinsurance	Covered under Tier 1 and Tier 2 only
Ambulance	When medically necessary	\$0 copay	10% coinsurance	20% coinsurance of MAC
Chiropractic services		\$30 copay per office visit	10% coinsurance	Covered under Tier 1 and Tier 2 only
Organ transplants	Out-of-pocket maximum applies	\$0 copay	20% coinsurance	Covered under Tier 1 and Tier 2 only

*Annual deductible must be satisfied for all services. **Maximum allowable charges (MAC) apply.

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Disclaimer:

TTY: 711

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