Health Plan Comparison

Benefit	LCHP		LCDHP		HMO	OAP Tier I (in-network)	OAP Tier II (in-network)	OAP Tier III (in-network)
Patient Responsibilities								
Annual Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**				
Per Enrollee	$2,000	$6,000	$5,000	$7,000	$3,000	$7,250 (Tier I and Tier II combined)		Not applicable
Per Family	$4,000	$12,000	$8,000	$14,000	$6,000	$13,750 (Tier I and Tier II combined)		Not applicable
Plan Year Deductible*								
Per Enrollee	$1,000 per enrollee		$2,000	$4,000	Not applicable	Not applicable	$400 per enrollee	$600 per enrollee
Per Family	$1,000 per enrollee		$4,000	$8,000			$400 per enrollee	$600 per enrollee
Plan Benefit Levels Comparison								
Annual Out-of-Pocket Maximum	**In-Network**	**Out-of-Network****	**In-Network**	**Out-of-Network****				
Emergency Room	$400 per visit; Deductible applies	$400 per visit; Deductible applies	80%; Deductible applies	80%; Deductible applies	$300	$300	$300	$300
Preventive Services including immunizations	100%	50% of allowable charges*	100%	No coverage	100%	100%	100%	Covered under Tier I and Tier II only
Inpatient	80% of network charges after $350 per visit*	50% of allowable charges after $600 per visit*	80% of network charges*	50% of allowable charges*	$350 copayment	$350 copayment	80% of network charges* after $400 copayment	50% of allowable charges* after $500 copayment
Outpatient Surgery	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	$300 copayment	$300 copayment	80% of network charges* after $300 copayment	50% of allowable charges* after $300 copayment
Diagnostic Lab and X-ray	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	100%	100%	80% of network charges*	50% of allowable charges*
Durable Medical Equipment	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	70% of network charges	70% of network charges	60% of network charges*	50% of allowable charges*
Physician Office Visit	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	$40 copayment	$40 copayment	80% of network charges*	50% of allowable charges*

Special note: Members enrolled in the LCDHP plan with one or more dependents on their coverage must satisfy the family annual plan year deductible before services will be covered at the plan's benefit level.

* The plan year deductible must be met before benefit levels will be applied.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region. Members who use out-of-network providers should contact their health plan administrator for information regarding out-of-network charges before obtaining services.