

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	OAP		
	Tier I – 100% Benefit	Tier II – 90% Benefit	Tier III – 80% Benefit
Covered Services			
Health Plan Year Deductible Per enrollee Note: The annual health plan deductible must be met before plan benefits apply	Not applicable	\$300	\$500
Out-of-Pocket Maximum* Individual Family	Not applicable	\$1,000 \$2,500	\$2,000 \$5,000
Physicians' Services	The Plan Pays	The Plan Pays	The Plan Pays
Physician or Specialist Office Visits • Treatment of illness or injury • Behavioral health	100% after \$30 copayment per visit	90% of network charges after the annual plan deductible	80% of U&C after the annual plan deductible
Physician or Specialist Office Visits • Wellness care/Preventive healthcare (including women's healthcare) are not subject to the health plan year deductible	100%	100%	Covered under Tier I and Tier II only
Outpatient Surgery • When billed as an office visit	100% after \$30 copayment per visit	90% of network charges after the annual plan deductible	80% of U&C after the annual plan deductible
Allergy Tests, Injections and Serum	100% after \$30 copayment per visit	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Hospital/Facility Services	The Plan Pays	The Plan Pays	The Plan Pays
Inpatient services	100% after \$250 copayment per admission	90% of network charges after the annual plan deductible and a \$300 copayment per admission	80% of U&C after the annual plan deductible and a \$400 copayment per admission
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization Note: Contact plan administrator regarding prior authorization	100% after \$250 copayment per admission	90% of network charges after the annual plan deductible and a \$300 copayment per admission	80% of U&C after the annual plan deductible and a \$400 copayment per admission

* For an explanation of out-of-pocket maximums see pages 12 and 13.

Note: See page 13 for an explanation of usual and customary (U&C) charges.

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	LCHP		HMO
	In-Network	Out-of-Network	In-Network
Hospital/Facility Services	The Plan Pays	The Plan Pays	The Plan Pays
Outpatient/Facility Surgery • When billed as outpatient surgery at a facility	90% after annual plan deductible	60% of U&C after the annual plan deductible	100% after \$200 copayment
Emergency Care – Hospital • Facility charges for treatment of emergency medical condition or injury Note: Professional fees may be billed separately	90% after the annual plan deductible and a \$400 emergency room deductible per visit	90% of U&C after the annual plan deductible and \$400 emergency room deductible per visit	100% after \$200 copayment per visit
Outpatient Testing, Lab, etc.	The Plan Pays	The Plan Pays	The Plan Pays
• Imaging • Diagnostic Tests	90% after annual plan deductible	60% of U&C after the annual plan deductible	100%
Other Coverage	The Plan Pays	The Plan Pays	The Plan Pays
Ambulance Service for Emergency Care	90% after annual plan deductible	90% of U&C after the annual plan deductible	100%
Home Health Care Services Note: Prior approval required	90% after annual plan deductible*	60% of U&C after the annual plan deductible*	100% after \$30 copayment per visit
Skilled Nursing Facility Services Note: Prior approval required	90% after annual plan deductible*	60% of U&C after the annual plan deductible*	100%
Hospice Care Note: Prior approval required	90% after annual plan deductible*	60% of U&C after the annual plan deductible*	100%
Durable Medical Equipment (DME) – Rental or purchase Note: Prior approval required for certain DME	90% after annual plan deductible	60% of U&C after the annual plan deductible	80% of U&C
Outpatient Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy	90% after annual plan deductible	60% of U&C after the annual plan deductible	100% after \$30 copayment per visit
Chiropractic Services Note: Chiropractic care for maintenance is not covered	90% after annual plan deductible, maximum 30 visits per plan year	60% of U&C after the annual plan deductible, maximum 30 visits per plan year	100% after \$30 copayment per visit

Note: See page 13 for an explanation of usual and customary (U&C) charges.

* See page 6 of the LCHP Summary Document on the Benefits website for benefit limitations.

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	OAP		
	Tier I – 100% Benefit	Tier II – 90% Benefit	Tier III – 80% Benefit
Hospital/Facility Services	The Plan Pays	The Plan Pays	The Plan Pays
Outpatient/Facility Surgery • When billed as outpatient surgery at a facility	100% after \$200 copayment	90% of network charges after the annual plan deductible and a \$200 copayment	80% of U&C after the annual plan deductible and a \$200 copayment
Emergency Care – Hospital • Facility charges for treatment of emergency medical condition or injury Note: Professional fees may be billed separately	100% after \$200 copayment per visit	100% after the annual plan deductible and a \$200 copayment per visit	100% after the annual plan deductible and a \$200 copayment per visit
Outpatient Testing, Lab, etc.	The Plan Pays	The Plan Pays	The Plan Pays
• Imaging • Diagnostic Tests	100%	90% of network charges after the annual plan deductible	80% of U&C after the annual plan deductible
Other Coverage	The Plan Pays	The Plan Pays	The Plan Pays
Ambulance Service for Emergency Care	100%	100%	100%
Home Health Care Services Note: Prior approval required	100% after \$30 copayment per visit	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Skilled Nursing Facility Services Note: Prior approval required	100%	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Hospice Care Note: Prior approval required	100%	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Durable Medical Equipment (DME) – Rental or purchase Note: Prior approval required for certain DME	80% of network charges	80% of network charges after the annual plan deductible	80% of U&C after the annual plan deductible
Outpatient Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy	100% after \$30 copayment per visit	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Chiropractic Services Note: Chiropractic care for maintenance is not covered	100% after \$30 copayment per visit, maximum 25 visits per plan year	90% of network charges after the annual plan deductible, maximum 25 visits per plan year	Covered under Tier I and Tier II only

Note: See page 13 for an explanation of usual and customary (U&C) charges.

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	LCHP		HMO
	In-Network	Out-of-Network	In-Network
Other Coverage	The Plan Pays	The Plan Pays	The Plan Pays
Transplant Services Note: Prior approval required	90% after the annual plan deductible and a \$250 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator.	Covered in-network only	100%
Pharmacy			
Copayments (30-day supply)			
Generic	\$12.50		\$12
Preferred Brand	\$25		\$24
Nonpreferred Brand	\$50		\$48
Specialty	\$100		\$96

Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100% of covered expenses for the remainder of the plan year. It is important to note that certain charges are always the member's responsibility and do not count toward the out-of-pocket maximum, nor are they covered after the out-of-pocket maximum has been met. Charges ineligible for payment by the plan include amounts over U&C, charges for noncovered services, prescription copayments, charges for services deemed to be not medically necessary and penalties for failing to precertify/provide notification. For the LCHP, \$50 of the Medicare A deductible is also the member's responsibility.

The types of charges that are applied toward the out-of-pocket maximum for each type of plan varies and are outlined below:

- **Local Care Health Plan:** The types of charges that apply toward the out-of-pocket maximum for LCHP include the annual plan deductible, additional deductibles and coinsurance.
- **HMO Plans:** HMO plans apply copayments toward the out-of-pocket maximum.
- **OAP Plans:** OAP plans do not have an out-of-pocket maximum for Tier I; however, for Tiers II and III, only coinsurance is applied toward the out-of-pocket maximum. Also for Tiers II and III, the out-of-pocket maximum amount must be met for each tier and are cumulative between tiers. For example, once the 'individual' out-of-pocket maximum for Tier II has been met (i.e., \$1,000), coinsurance for Tier II providers is no longer required. However, if the same plan participant then goes to a Tier III provider (out-of-network), they will need to satisfy an additional \$1,000 to meet the out-of-pocket maximum for Tier III charges (i.e., \$2,000).

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	OAP		
	Tier I – 100% Benefit	Tier II – 90% Benefit	Tier III – 80% Benefit
Other Coverage	The Plan Pays	The Plan Pays	The Plan Pays
Transplant Services Note: Prior approval required	100%	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Pharmacy			
Copayments (30-day supply)			
Generic		\$12	
Preferred Brand		\$24	
Nonpreferred Brand		\$48	
Specialty		\$96	

Out-of-Pocket Maximums Chart

PLAN	Out-of-Pocket Maximum Limits	CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM			
		Annual Plan Year Deductible	Additional Deductibles/ Copayments	Coinsurance	Amounts over U&C* (LCHP out-of-network providers and OAP Tier III providers)
LCHP	In-Network Individual \$1,500 Family \$3,000 Out-of-Network Individual \$4,500 Family \$9,000	X	X	X	Amounts over U&C are the member's responsibility and do not go toward the out-of-pocket maximum.
HMO	Individual \$3,000 Family \$6,000		X		
OAP Tier II	Individual \$1,000 Family \$2,500			X	
OAP Tier III	Individual \$2,000 Family \$5,000			X	

* Usual and customary (U&C) is applied to charges accrued when utilizing an out-of-network provider. For example, if an out-of-network provider charges \$1,000 for a procedure, but the U&C cost for the procedure is \$800, the percentage of coinsurance that the plan will pay is based on the \$800. The \$200 difference between the charges for the procedure and the U&C cost (\$1,000-\$800) is always the member's responsibility.