Lovelace
Community Health Plan

Lovelace State Coverage Insurance (SCI) Benefit Summary*

Provider Services	062-0-A	062-B	062-C
Office visits	$0	$5 per visit	$7 per visit
Home visits	$0	$5 per visit	$7 per visit
Hospital & Inpatient Rehab visit	None	None	None
Office procedure	Covered as part of office visit co-payment	Covered as part of office visit co-payment	Covered as part of office visit co-payment
[1]Inpatient professional care services of providers (incl. pathologists, radiologists, and anesthesiologists)	None	None	None
Allergy testing, injection, and serum	Office visit co-payment	Office visit co-payment	Office visit co-payment
Routine and diagnostic X-rays, clinical laboratory tests, electrocardiograms (EKGs), and electroencephalograms (EEGs)	None	None	None
Inpatient Hospital Services and Maternity Care	$0	$25 per admission	$30 per admission
Outpatient Surgeries (incl. Operating, delivery, recovery, treatment rooms, equipment and supplies including anesthesia, dressing and medications)	$0	$5 per procedure	$7 per procedure
Radiation therapy and chemotherapy	$0	$5 per visit	$7 per visit
Magnetic Resonance Imaging (MRI)	$0	$5 per visit	$7 per visit
Positron Emission Tomography (PET)	$0	$5 per visit	$7 per visit
CT Scan	$0	$5 per visit	$7 per visit
Outpatient Rehabilitative services – physical, occupational, and speech therapy	$0	$5 per visit	$7 per visit
Emergency Health Services	$0	$15 per visit (waived if admitted to hospital within 24 hrs of emergency room visit)	$20 per visit (waived if admitted to hospital within 24 hrs of emergency room visit)
Home visits	$0	$5 per visit	$7 per visit
Preventive Health Services			
Physical Exams	$0	$5 per visit	$7 per visit

[1] Inpatient hospitalization (including maternity), inpatient rehabilitation, and home health is limited in total to twenty-five (25) days per benefit year.

* The Lovelace SCI benefit package, excluding enhanced benefits, is limited to a $100,000 benefit disbursement per member, per year. In addition, the benefits listed above do not represent an all-inclusive list of the benefits or their applicable limitations. Please refer to the Lovelace SCI Member Handbook for a detailed description of benefits, exclusions and limitations.

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Women's Health Services	062-0-A	062-B	062-C
Office visits	$0	$5 per visit	$7 per visit
Low dose mammography screening for detection of breast cancer in a radiological facility	Included in office visit	Included in office visit	Included in office visit
Cytological screening to determine the presence of precancerous or cancerous conditions or other health problems	Included in office visit	Included in office visit	Included in office visit
Home Births (prior authorization is required)	$25	$75	$100
Vision Services (Lovelace Enhanced Benefit)			
1 eye exam every 2 years; 1 pair of eyeglasses with frames limited to $17 every 2 years.	None	None	None
Other Services			
Ambulance Services (life threatening circumstances only)	None	None	None
Dialysis Services	None	None	None
[1] Inpatient physical rehabilitation facility coverage.	$0	$25 per day	$30 per day
[1]Home Health Services	$0	$5 per visit	$7 per visit
Skilled Nursing facility only to a step-down unit for post-acute inpatient treatment for purposes of rehabilitation	$0	$25 per day	$30 per day
Durable Medical Equipment, Medical Supplies, Orthotics over $200 of allowable charges per item	$0 per item	$5 per item	$7 per item
Limited Oral Surgery	Co-payment based on place of service	Co-payment based on place of service	Co-payment based on place of service
Reconstructive Surgery	Co-payment based on place of service	Co-payment based on place of service	Co-payment based on place of service
Prescription Drugs – generic and brand name drugs on the LCHP formulary	$3 generic and/or brand name (maximum member responsibility of $12 per/month)	$3 generic and/or brand name (maximum member responsibility of $12 per/month)	$3 generic and/or brand name (maximum member responsibility of $12 per/month)

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Diabetes Services	062-0-A	062-B	062-C
Diabetes Equipment, supplies and appliances – 2 Vials of insulin per co-payment	$3 generic and/or brand name	$3 generic and/or brand name	$3 generic and/or brand name
Diabetes self-management training	$0	$5 per visit	$7 per visit
Behavioral Health Services			
Outpatient office visits	$0	$5 per visit	$7 per visit
Inpatient mental health evaluation/ treatment and partial hospitalization provided in a psychiatric hospital or an acute general hospital – prior authorization is required. (Limited to 25 days per benefit year)	$0	$25 per visit	$30 per visit
Substance Abuse Services			
Outpatient and Intensive Outpatient (IOP) substance abuse treatment (Limited to 42 visits per benefit year)	$0	$5 per visit	$7 per visit
Outpatient Detox (Limited to 10 days per benefit year & counts towards 42 visit outpatient limit)	$0	$5 per visit	$7 per visit
Inpatient Detox (Limited to 72 hours per occurrence & counts towards 25 day mental health inpatient limit)	$0	$25 per admission	$30 per admission

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