

## LAUREL HEALTH SYSTEM MEDICAL PLAN

### HSA SUMMARY DESCRIPTION

#### HSA Plan

#### Overall Maximum Benefit

**Active Employees** .....\$1,000,000

#### Percentage Payable for Covered Expenses (Unless Otherwise Specifically Stated within this Plan)

**Network Provider (after deductible)** ..... 90% of first \$10,000

**Non-Network Provider** ..... **NOT COVERED**

#### Deductible

Per Person .....\$1,000

Per Family (aggregate) .....\$2,000

#### Out-of-Pocket Maximum (includes deductible)

Per Person .....\$2,000

Per Family (aggregate) .....\$4,000

#### Physician Services

##### Office Visit (Preventative Care Only)

**\$25-preventative care only-up to a maximum of \$500.0**

**Other than Office Visit** (Includes In-Hospital Physician visits, inpatient surgical procedures, anesthesiology, radiology and pathology interpretation)

**The following Radiological procedures will be required to be performed at Soldiers + Sailors Memorial Hospital for individuals that live in Tioga County even if they have been referred to providers out of the county: MRI, CT, Nuclear Medicine, Mammography and Dexa Scan(bone densitometry)**

**Network Provider (after Deductible)** ..... 90%

**Non-Network Provider** ..... **NOT COVERED**

#### Diagnostic, Laboratory and X-Ray Services

**(The following Radiological procedures will be required to be performed at Soldiers + Sailors Memorial Hospital for individuals that live in Tioga County even if they have been referred to providers out of the county: MRI, CT, Nuclear Medicine, Mammography and Dexa Scan(bone densitometry)**

**Network Provider (after Deductible)** ..... 80%

<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>
<b>Pregnancy/Maternity</b> .....	80% After Deductible
<b>Network Provider (after deductible)</b> .....	80%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>
<b>Emergency Room Services</b> (Includes Physician and Facility Expenses)	
Network Provider.....	80% after deductible
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>
(Please refer to the Out Of Service Area Provider Provision in your plan handbook).	
<b>Hospital Expenses</b>	
<b>Inpatient Hospital Expenses (Pre-Certification Required)</b>	
<b>Network Provider (after Deductible)</b> .....	80%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>
<b>Room &amp; Board Allowance</b>	
Semi-Private .....	Up to Hospital's Most Common Semi-Private Room Rate
Intensive Care .....	Up to Hospital's Actual Charge
Private.....	Up to Hospital's Most Common Semi-Private Room Rate
When the hospital has only Private Room accommodations and does not have a Most Common Semi-Private Rate, the Hospital's Most Common Private Room Rate will be used.	
<b>Outpatient Hospital Expenses</b> (Includes diagnostic laboratory and x-ray services)	
<b>Network Provider (after Deductible)</b> .....	80%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>
<b>Ambulance Services (after Deductible)</b> .....	80%
<b>Therapy Services</b>	
<b>Speech Therapy</b>	
Maximum Visits per Benefit plan year .....	36
<b>Network Provider (after Deductible)</b> .....	90%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>
<b>Physical Therapy</b>	
Maximum Visits per Benefit plan year .....	36
<b>Network Provider (after Deductible)</b> .....	90%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>
<b>Occupational Therapy</b>	
Maximum Visits per Benefit plan year .....	36
<b>Network Provider (after Deductible)</b> .....	90%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>

**Mental Health Treatment (Pre-Certification Required)**

**Inpatient Hospitalization**

Maximum Days per Benefit plan year.....	30 Consecutive Days
<b>Network Provider (after Deductible)</b> .....	90%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>

**Partial Hospitalization** – Treated as an inpatient confinement. Each visit/day will be counted as ½ day of inpatient confinement toward the 30 day maximum.

**Outpatient Services (no Pre-Certification necessary)**

Maximum Outpatient Visits per Benefit plan year.....	30
<b>Network Provider (after Deductible)</b> .....	80%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>

**Substance Abuse Treatment (Pre-Certification Required)**

**Inpatient Hospitalization**

Maximum Inpatient Days

Detoxification per Benefit plan year .....	7
Overall Maximum Detoxification Periods.....	4
Maximum Inpatient Rehabilitation Days per Benefit plan year .....	30
Overall Maximum Inpatient Rehabilitation Days.....	90
<b>Network Provider (after Deductible)</b> .....	90%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>

**Partial Hospitalization** – Treated as an inpatient confinement. Each visit/day will be counted as ½ day of inpatient confinement and applied toward the maximums stated above.

**Outpatient Services**

Maximum Outpatient Visits per Benefit plan year.....	30
<b>Network Provider (after Deductible)</b> .....	80%
<b>Non-Network Provider</b> .....	<b>NOT COVERED</b>

**Chiropractic Treatment and Osteopathic Manipulation (X-rays must be performed at a Network Hospital to be a covered expense)**

Combined Maximum Outpatient Visits per Benefit plan year.....	12
<b>Network Provider</b> .....	60% After Deductible – 12 Visits/Plan Year

**Durable Medical Equipment, Prosthetic and Orthotic Appliances**

**(after deductible)**..... 80%

Orthotic appliances are covered only when prescribed by an orthopedic surgeon or a podiatrist. This does not include benefits for orthotics for the feet.

**Preventive Care** (A \$25 copayment will be applied to the office visit for all preventive care). This co-pay will be waived for the annual physical examination for the employee only.)

Gynecological and physical examination limited to one examination each benefit plan year. Pap smear, mammogram, PSA testing limited to once each benefit plan year

Immunizations limited to a child under the age of 16. Serum expenses are paid at 100%.

**\*The plan year deductible is waived.**

**Hospice Care (Pre-Certification Required)**

Overall Maximum Benefit.....180 Days

Bereavement Counseling Maximum..... 2 Visits

**Network Provider (after Deductible)..... 90%**

**Non-Network Provider..... NOT COVERED**

**Home Health Care & Home Infusion Therapy (Pre-Certification Required)**

Maximum number of visits per benefit plan year.....100

**Network Provider (after Deductible)..... 90%**

**Non-Network Provider..... NOT COVERED**

**Skilled Nursing Facility (Pre-Certification Required)**

Maximum number of days per benefit plan year.....120

Room and Board Limit..... Semi-Private Room Rate

**Network Provider (after Deductible)..... 90%**

**Non-Network Provider..... NOT COVERED**

**Diabetes Education Services**

Diabetes Self-Management Education limited to..... 1 Program

Diabetes Consultation ..... 1 consultation per benefit plan year  
(provided the Covered Person completes the diabetes education program)

**Maximum Benefit for a Wig due to hair loss following chemotherapy/radiation treatment**

**Network Provider (after Deductible).....\$300**

**Pharmacy Co-payment, per Prescription (30 day supply)**

For Generic Drugs ..... 80% After Deductible

For Preferred Brand Drugs..... 80% After Deductible

For Non-Preferred Brand Drugs ..... 80% After Deductible

**Mail Order Co-payment, per Prescription using SSMH Pharmacy (60 day supply)**

For Generic Drugs..... 80% After Deductible

For Preferred Brand Drugs..... 80% After Deductible

For Non-Preferred Brand..... 80% After Deductible