LAUREL® HEALTH SYSTEM

TYOGA CareNet

LAUREL HEALTH SYSTEM MEDICAL PLAN

BASIC PLAN SUMMARY DESCRIPTION

Basic Plan

Overall Maximum Benefit
- **Active Employees**.......$1,000,000
- **Retired Employees (Grandfathered)**.......$250,000

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.......$1,750
- Per Family (aggregate).......$3,500

Physician Services

Office Visit (Office Visit charge only, including physician charges for surgery performed in physician's office) (Does not include diagnostic, laboratory, x-ray services)
- **Network Provider**....... 100%
  - After a Copayment Per Office Visit of.......$25
    (unless other specified in the Plan)
  - After a Copayment Per In-office Surgery of.......$30
- **Non-Network Provider**....... **NOT COVERED**

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) 90%
Non-Network Provider .... **NOT COVERED**

Pregnancy/Maternity...Same As Any Other Illness
Network Provider (after deductible)... 90%
After a Copayment for initial office visit only of...$30
Non-Network Provider .... **NOT COVERED**

Emergency Room Services (Includes Physician and Facility Expenses)

Network Provider.. 100%

After a Copayment per Visit of $50
Non-Network Provider .... **NOT COVERED**
(Please refer to the Out Of Service Area Provider Provision in your plan handbook).

Hospital Expenses

Inpatient Hospital Expenses (Pre-Certification Required)
Network Provider (after Deductible) 90%
Non-Network Provider .... **NOT COVERED**

Room & Board Allowance
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.

Outpatient Hospital Expenses (Includes diagnostic laboratory and x-ray services)
Network Provider (after Deductible) 90%
Non-Network Provider .... **NOT COVERED**

Ambulance Services (after Deductible) 80%

Therapy Services

Speech Therapy
Maximum Visits per Benefit plan year 36
Network Provider (after Deductible) 90%
Non-Network Provider .... **NOT COVERED**

Physical Therapy

Maximum Visits per Benefit plan year 36
Network Provider (after Deductible) 90%
Non-Network Provider .... **NOT COVERED**

Occupational Therapy

Maximum Visits per Benefit plan year 36
Network Provider (after Deductible) 90%
Non-Network Provider .... **NOT COVERED**

Mental Health Treatment (Pre-Certification Required)

Inpatient Hospitalization

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

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
Network Provider (after Deductible) 80%
Non-Network Provider .... **NOT COVERED**

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
Network Provider (after Deductible) 90%
Non-Network Provider .... **NOT COVERED**

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
Network Provider (after Deductible) 80%
Non-Network Provider .... **NOT COVERED**

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
Network Provider 60%

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 $20.00

For Preferred Brand Drugs...$40.00

For Non-Preferred Brand Drugs $50.00

*Preferred and Non-Preferred Brand prescriptions will be discounted by $5.00 when filled at the SSMH Pharmacy

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

For Generic Drugs $20.00

For Preferred Brand Drugs $40.00

For Non-Preferred Brand...$50.00