Town of Southold

Island Group Administration, Inc.

Services	Participating Provider	Non-Participating Provider
Calendar Year Deductible Individual/Family	None	$363 Individual /$363 Spouse/ $363 Dependent Children Combined
Covered Percentage	N/A	80% of UCR of Covered Expenses
Out of Pocket Expenses (Excludes Prescriptions)	N/A	$1000 Individual; $3000 Family
Maximum Benefit	$1,000,000 per Year	$1,000,000 per Year; Substance Abuse$50,000 Maximum Lifetime $250,000
Pre Certification Required	All Hospital Admissions, Pregnancy, Ambulatory Surgery, MRI, MRA, CAT-SCANS, Cardiac Rehab, Hospice Care, Physical Therapy, Occupational Therapy, Speech Therapy, Home Healthcare Services, Home Infusion Therapy, Durable Medical Supplies, Prosthetics	All Hospital Admissions, Pregnancy, Ambulatory Surgery, MRI, MRA, CAT-SCANS, Cardiac Rehab, Hospice Care, Physical Therapy, Occupational Therapy, Speech Therapy, Home Healthcare Services, Home Infusion Therapy, Durable Medical Supplies, Prosthetics
Dependent Eligibility	Age 19 or Age 25 Full Time Students	Age 19 or Age 25 Full Time Students
Hospital		
Medical Inpatient	Covered in Full	10% of billed charges up to annual inpatient/outpatient combined coinsurance maximum of $1500 yourself / $1500 Spouse / $1500 Children
Pre-certification Required within 48 Hours - penalty $200 and $100 per day that is not medically necessary - Semi Private Room Only		
Outpatient Services	Covered in Full Less $35 Co Pay	10% of billed charges or $75 (whichever is greater) up to a combined annual inpatient/outpatient coinsurance maximum of $1500 for yourself / $1500 for spouse / $1500 for all children combined.
(No Co Pay for Radiation Therapy, Chemotherapy, and Dialysis. One Co Pay per Hospital visit for all other visits)		
Physical Therapy - Outpatient Services	Covered in Full Less $20 Co Pay	10% of billed charges or $75 (whichever is greater) up to a combined annual inpatient/outpatient coinsurance maximum of $1500 for yourself / $1500 for spouse / $1500 for all children combined.
Ambulatory Surgery Center	Covered in Full Less $30 Co Pay	80% UCR after satisfaction of deductible
Preadmission Testing (Within 14 days of Surgery)	Covered in Full	100% of Covered Expenses
Hospice Care (NY State Certified Facility)	Covered in Full	10% of billed charges up to annual inpatient/outpatient combined coinsurance maximum of $1500 yourself / $1500 Spouse / $1500 Children
Skilled Nursing Facility *	Covered in Full; Up to 365 Days per Year	10% of billed charges up to annual inpatient/outpatient combined coinsurance maximum of $1500 yourself / $1500 Spouse / $1500 Children
*** Call Island Group for Requirements. Pre-Certification is required or Admission will not be covered. Retirees who have Medicare Primary are not eligible to receive benefits**		
Physician Services		
Office Visits	$20.00 Co Pay per procedure per date of service	80% of Covered Expenses After Satisfaction of Deductible
InPatient Services	Covered in Full After Office Visit Co Pay	80% of Covered Expenses After Satisfaction of Deductible
Routine Adult Physical Exams *	Covered in Full After Office Visit Co Pay	$250 once every year for Active Employees 50 or Older
		$250 once every year for Spouse 50 or Older
		Not Subject to Deductible/ Coinsurance (No Coverage for Retirees or Dependent survivors)
Adult Immunizations	Covered in Full After Office Visit Co Pay	Not Covered
Influenza, Pneumonia, Measles, Mumps, Rubella (MMR), Varicella (Chicken Pox) and Tetanus		
Mammography	Covered in Full After Office Visit Co Pay	80% of Covered Expenses After Satisfaction of Deductible
Pap Smears	Covered in Full After Office Visit Co Pay	80% of Covered Expenses After Satisfaction of Deductible
Well Child Care (to Age 19 Years)	Covered in Full	80% of Covered Expenses After Satisfaction of Deductible
Diagnostic Tests, X-Rays Etc.	Covered in Full After Office Visit Co Pay	80% of Covered Expenses After Satisfaction of Deductible
Laboratory Services	Covered in Full After Office Visit Co Pay	80% of Covered Expenses After Satisfaction of Deductible
Surgery (Free Standing Ambulatory $30 Co Pay)	Covered in Full After Office Visit Co Pay	80% of Covered Expenses After Satisfaction of Deductible
Sterilization	Covered in Full After Office Visit Co Pay	80% of Covered Expenses After Satisfaction of Deductible
Anesthesiology	Covered in Full After Office Visit Co Pay	80% of Covered Expenses After Satisfaction of Deductible
New Born Care	Covered in Full	100% UCR - Maximum Benefit $150 - Not subject to Deductible / Coinsurance
Maternity	Covered in Full	80% of Covered Expenses After Satisfaction of Deductible

Effective 1/1/10

Town of Southold

Island Group Administration, Inc.

Services	Participating Provider	Non-Participating Provider
Infertility Treatment	Covered in Full After Office Visit Co Pay	80% of UCR of Covered Expenses after Satisfaction of Deductible
Care must be Preauthorized thru Island Group or No Benefits are available for Qualified Procedures under the Hospital or Medical program, regardless of the Provider.		
Qualified procedures are covered to a lifetime maximum of $50,000 per covered person		
Circumcision	Covered in Full After Office Visit Co Pay	80% of UCR of Covered Expenses after Satisfaction of Deductible
Chiropractic Services	Covered in Full After Office Visit Co Pay	50%Network Allowance After Satisfaction of $250 Physical Medicine Deductible per person
No Modalities	Max 2 Co Pays per visit	Subject to Maximum Annual Benefit of $1500 per Year
Mental Health		
Outpatient Precertification required	Covered in Full After $20 Co Pay	80% of covered expenses after satisfaction of $363 Mental Health Deductible
Inpatient Precertification required	Covered in Full	90% Billed Charges; 100% after $1000 mental health coinsurance
Substance Abuse		Out of network Maximums Annual $50,000 Lifetime $250,000
Outpatient Precertification required	Covered in Full after $20 Co Pay	50%Network Allowance After Satisfaction of $500 Substance Abuse Deductible per person
Inpatient Including Detox	Covered in Full (3 Stays per Lifetime)	50%Network Allowance after satisfaction of $2000 Substance Abuse Deductible
(Precertification required.)		One Stay per Year & 3 Stays per Lifetime (up to 7 weeks)
Other		
Physical, Occupational, Speech Therapy	Covered in Full After Office Visit Co Pay	50%Network Allowance After Satisfaction of $250 Physical Medicine Deductible
Letter of Medical Necessity & Closed ended prescription from Referring Physician required.		Subject to an Annual Maximum Benefit of $1500
Treatments must start within 6 months from hospital discharge or surgery. No Payment after 365 days from the date of surgery or discharge.		
Hearing Aid	Covered in Full up to $1500 per hearing aid per ear in any 48 months	Covered in Full up to $1500 per hearing aid per ear in any 48 months
(Thru Age 12 Years Covered in Full to $1500; Every 2 Years)		
Home Health Care	Covered in Full	1st 48 hrs are not covered. 50% of network allowance after satisfaction of deductible
(Must Call Island Group for Prior Approval. Custodial Care not covered. 365 Visits per Year Maximum In and Out of Network) Each day of care = 1/3 benefit day of care.		
Durable Medical Equipment	Covered in Full	50% of PP rate after satisfaction of deductible
(Must Call Island Group for Prior Approval) Letter of Medical Necessity & Closed ended prescription from Referring Physician required		
Prosthetics		
Internal and External	Covered in Full - Prosthetics replaced when functionally necessary	80% of covered expense after satisfaction of deductible.
Emergency Services	(Must Satisfy the definition of an Emergency)	(Must Satisfy the definition of an Emergency)
Hospital	Covered in Full After $60 Co Pay	100% of Covered Expenses less $60 Co Pay
Emergency Room Physician	Covered in Full	100% of In-Network Fees
Ambulance	Covered in Full After $35 Co Pay	Professional Ambulance Covered in Full after $35 Co Pay
Volunteer Ambulance covered in Full up to $50 under 50 Miles and $75 over 50 Miles		
Prescriptions (Card Plan)		
Brand only Co Pay - Coumadin, Dilantin, Lanoxin, Levothyroid, Mysoline, Premarin, Synthyroid, Tegretol		
Up to 30 Day Supply - Retail or Mail Order	$5.00 Generic/ $15 Brand with no generic Equivalent or $40 Brand Co Pay	Plus the difference between the generic and brand when generic is available
31-90 Day Supply @ Retail	$10.00 Generic/ $30 Brand with no generic Equivalent or $70 Brand Co Pay	Plus the difference between the generic and brand when generic is available
31-90 Day Supply @ Mail Order	$5.00 Generic/ $20 Brand with no generic Equivalent or $65 Brand Co Pay	Plus the difference between the generic and brand when generic is available
Diabetic Supplies	Covered in Full	Covered at 50% Subject to Deductible and Coinsurance