


# Liberty Central School District Island 65 Plan

Effective 7/1/02

<b>The Following Benefits are paid secondarily to Medicare</b>		
<b>Services</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>
<b>Calendar Year Deductible - Individual/Family</b>	None	\$200 Individual / \$500 Family
<b>Covered Percentage</b>	Not Applicable	20% of the lesser of charges or the allowed amount
<b>Annual Coinsurance - Individual/Family</b>	Not Applicable (Excludes Prescriptions)	\$842 Individual; \$842 Family (Excludes Prescriptions)
<b>Pre-Certification - -</b> Inpatient admissions, inpatient/outpatient	physical therapy, ambulatory surgery, cardiac rehab, home health care, MRI, Hospice,	occupational/speech/vision therapy, skilled nursing facilities, home infusion therapy, prosthetics, orthotics, DME
<b>Maximum Benefit</b>	\$1,000,000 per Year	\$1,000,000 per Year
<b>Dependent Eligibility</b>	Medicare eligible district retiree and their eligible dependents	Medicare eligible district retiree and their eligible dependents
<b>Hospital</b>		
<b>Medical Inpatient</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Outpatient Lab, X-Rays, Mammogram</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Physical Therapy - Inpatient</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Physical Therapy - Outpatient</b>	Covered in Full less \$10 copay	Network Only - Requires pre-approval.
Following related Surgery or Hospitalization. Letter of Medical Necessity and Closed ended prescription required.		
<b>Ambulatory Surgery</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Preadmission Testing (within 14 days of Surgery)</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Hospice (lifetime maximum of 210 days)</b>	Covered in Full	Not Covered
<b>Skilled Nursing Facility</b>	Covered in Full	Not covered.
<b>Physician Services</b>		
<b>Office Visits</b>	\$10.00 Co Pay	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>InPatient Services</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Routine Adult Physical Examinations</b>	Covered in Full After \$10.00 Co Pay	Not Covered
<b>Mammography (Yearly) &amp; Pap Smears</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Diagnostic Tests, X-Rays Etc.</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Ambulatory Surgery Center (free standing)</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Laboratory Services</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Surgery</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Anesthesiology (Surgery and Maternity only)</b>	Covered in Full	Covered at 80% of allowable amount subject to deductible & coinsurance
 <p style="font-size: small; margin: 0;">ISLAND GROUP ADMINISTRATION, INC. <b>ISLAND GROUP</b></p>		

\*\*\*Contact Island Group (1-800-926-2306) for specific information and exclusions.

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Services	Participating Provider	Non-Participating Provider
<b>Chiropractic Care</b>	Covered in Full After Office Visit CoPay	Covered at 80% of allowable amount subject to deductible & coinsurance
<b>Mental Health</b>		
<b>Outpatient (Precertification Required)</b>	Covered in Full After \$25 CoPay- max 60 visits per year	50% of Allowable Amount After Satisfaction of Deductible-max 60 visits per yr
<b>Inpatient or Hospital Day Treatment</b> Precertification required -- up to 120 days per spell of illness	Covered in Full	50% of Allowable Amount After Satisfaction of Deductible
<b>Substance Abuse</b>		
<b>Outpatient</b>	Covered in Full-60 visits per year - 20 family visits	Covered at 80% of allowable amount subject to deductible & coinsurance 60 visits per year - 20 family visits
<b>Inpatient including Detox</b> (30 Day Maximum per Calendar year)	Covered in Full	50% of Allowable Amount After Satisfaction of Deductible
<b>Other</b>		
<b>Physical, Occupational, Speech Therapy</b> (Letter of Medical Necessity & Closed ended prescription from Referring Physician required.) (Occupational, Speech & Vision Therapy limited to 30 visits per year for any combination of the three)	\$10 Copay	Not covered
<b>Hearing Aid</b>	Not covered	Not covered
<b>Home Nursing Services</b> ( 365 visits maximum per year in and out of network. MD order and letter of medical necessity required. Custodial Care not covered. )	Covered in Full	Covered at 80% of allowable amount not subject to deductible
<b>Home Infusion Therapy</b>	Covered in Full	Not covered
<b>Durable Medical Equipment</b>	Covered in Full	Not covered
<b>Orthotics and Prosthetics</b>		
<b>Internal and External</b> Prior authorization Required. MD Order and Letter of Medical necessity.	Covered in Full	Not covered
<b>Emergency Services</b>	<b>(Must Satisfy the definition of an Emergency)</b>	<b>(Must Satisfy the definition of an Emergency)</b>
<b>Hospital</b>	Covered in Full After \$35 CoPay	100% of Covered Expenses less \$35 CoPay
<b>Ambulance</b> Air Ambulance and Ambulette NOT COVERED	Covered in Full	Covered in Full
<b>Prescriptions (Card Plan)</b>		
<b>Generic/Brand w/o generic equivalent</b>	Contraceptives Not Covered	
<b>Diabetic Supplies</b>	\$5.00 CoPay / Difference in cost generic/brand	
<b>Diabetic Supplies</b>	Covered in Full	Covered at 80% of Allowable Amount Subject to Deductible and Co-Insurance
<b>Mail Order</b>	\$1 CoPay	