

# Marder's Health Benefits

## Island Group Administration, Inc.

Effective 3/1/11

Services	Participating Provider	Non-Participating Provider
Calendar Year Deductible Individual/Family	N/A	\$500 Individual /\$1250 Family
Covered Percentage	N/A	70% of Covered Expenses
Out of Pocket Expenses (Excludes Prescriptions)	N/A	\$3000 Individual; \$7500 Family
Maximum Benefit	\$1,000,000 per Year	\$1,000,000 per Year
Pre Certification Required	All Hospital Admissions (Including Skilled Nursing Facility), Pregnancy, I/P Physical Therapy, Ambulatory Surgery, Cardiac Rehabilitation, MRI, MRA, Hospice Care, Physical, Occupational, Speech Therapy, Home Health Care Services, Home Infusion Therapy, Durable Medical, Orthotics, Prosthetics	All Hospital Admissions (Including Skilled Nursing Facility), Pregnancy, I/P Physical Therapy, Ambulatory Surgery, Cardiac Rehabilitation, MRI, MRA, Hospice Care, Physical, Occupational, Speech Therapy, Home Health Care Services, Home Infusion Therapy, Durable Medical, Orthotics, Prosthetics
Dependent Eligibility	Age 19 or Age 26 if eligible (Contact your employer for information regarding eligibility of your adult children)	Age 19 or Age 26 if eligible (Contact your employer for information regarding eligibility of your adult children)
<b>Hospital</b>		
Medical Inpatient Pre-certification Required within 48 Hours - Semi Private Room Only	\$500 CoPay per Inpatient Stay	70% of Covered Expenses After Satisfaction of Deductible
Outpatient Services	Laboratory \$25 CoPay Radiology \$30 CoPay Surgery \$50 CoPay	70% of Covered Expenses After Satisfaction of Deductible 70% of Covered Expenses After Satisfaction of Deductible 70% of Covered Expenses After Satisfaction of Deductible
Physical Therapy - Outpatient Services	Covered in Full Less \$30 CoPay	Not Covered
Ambulatory Surgery Center	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Newborn Nursery	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Preadmission Testing (Within 14 days of Surgery)	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Hospice Care (NY State Certified Facility) *Up to 210 days per Lifetime	Covered in Full	Not Covered
Skilled Nursing Facility *	Covered in Full; Up to 60 Days per Year	Not Covered
<b>Physician Services</b>		
Office Visits	\$30.00 CoPay	70% of Covered Expenses After Satisfaction of Deductible
InPatient Services	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Routine Adult Physical Exams * *One Visit Per Year	Covered in Full	Not Covered
Adult Immunizations Influenza, Pneumonia, Measles, Mumps, Rubella (MMR), Varicella (Chicken Pox), Tetanus,HPV (age 19-26), Meningitis, and Herpes Zoster (age 60+.)	Covered in Full	Not Covered Zoster covered for age 55-59 with a \$20 copay.
Pap Smears/Mammography		70% of Covered Expenses After Satisfaction of Deductible
Well Child Care (to Age 19 Years)	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Diagnostic Tests, X-Rays Etc.	Covered in Full after Office Visit CoPay	70% of Covered Expenses After Satisfaction of Deductible
Allergy Testing	Covered in Full After Office Visit CoPay	70% of Covered Expenses After Satisfaction of Deductible
Allergy Treatment	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Laboratory Services including independent labs	Covered in Full after Office Visit CoPay	70% of Covered Expenses After Satisfaction of Deductible
Surgery	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Anesthesiology	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
New Born Care	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Maternity	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible

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Infertility Treatment	Not Covered	Not Covered
Circumcision	Covered in Full	70% of Covered Expenses after Satisfaction of Deductible
Chiropractic Services No Modalities - Up to 30 Visits per Year	Covered in Full After Office Visit CoPay	70% of Covered Expenses After Satisfaction of Deductible
<b>Mental Health</b>		
Outpatient Precertification required *20 Visits Per Year	Covered in Full After \$35 CoPay	Not Covered
Inpatient Precertification required *30 Days Per Year	\$500 CoPay per Inpatient Stay	Not Covered
<b>Substance Abuse</b>		
Outpatient Precertification required 60 Visits Per Year	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Inpatient <u>DETOX ONLY</u> ( Precertification required)	Covered in Full - Up to 7 Days Per Year	Not Covered
<b>Other</b>		
Physical, Occupational, Speech Therapy *30 Visits Per Year- Letter of Medical Necessity & Closed ended prescription from Referring Physician required.	Covered in Full After Office Visit CoPay	Not Covered
Inpatient Physical Rehabilitation *Pre Certification Required	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Home Health Care (Must Call Island Group for Prior Approval. Custodial Care Not Covered. 200 Visits per Year Maximum In and Out of Network)	Covered in Full	70% of Covered Expenses NOT Subject to Deductible *Home IV Therapy Not Covered
Durable Medical Equipment (Must Call Island Group for Prior Approval) Letter of Medical Necessity from Referring Physician required	Covered in Full	Not Covered
Medical Supplies	Covered in Full	Difference between allowed amount and total charged NOT subject to deductible or coinsurance
<b>Prosthetics</b>		
Internal and External (Must Call Island Group for Prior Approval) Letter of Medical Necessity from Referring Physician required	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>
Hospital	Covered in Full After \$250 CoPay	Covered in Full After \$250 CoPay
Emergency Room Physician	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Ambulance	Covered in Full	Covered in Full up to allowed amount. Employee pays difference between allowed amount and total charged.
<b>Prescriptions (Card Plan) Mandatory Mail Order after 2 refills for Maintenance Drugs</b>		
Generic/ Brand	\$10.00 Generic/ \$35 Brand with no generic Equivalent or \$50 Brand copay plus the difference between the generic and brand when generic is available	
Diabetic Supplies	Covered in Full	70% of Covered Expenses After Satisfaction of Deductible
Mail Order	\$10.00 Generic/ \$35 Brand with no generic Equivalent or \$50 Brand copay plus the difference between the generic and brand when generic is available	
CoPays are Per 30 Day Supply		