



## TOWN OF NORTH HEMPSTEAD ISLAND 65 BENEFIT SUMMARY

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### GENERAL CONDITIONS

Lifetime Maximum Benefit (per person)	Unlimited
Annual Maximum Benefit (per person)	Unlimited

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<b>Deductible</b>	N/A	\$1,000 per individual; \$1,000 spouse; \$1,000 for all dependent children combined
<b>Maximum Out-of-Pocket Expense</b>	N/A	\$3,000 per individual; \$3,000 spouse; \$3,000 for all dependent children combined

### HOSPITAL SERVICES

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<b>Hospital Inpatient Services</b> <i>Precertification required</i> (Including Maternity care and Newborn care from birth on; and mental health, and substance abuse services)	Covered in Full	10% of billed charges to annual inpatient/ outpatient combined coinsurance maximum of \$3000 yourself/\$3000 Spouse/\$3000 children combined. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.
<b>Hospital Outpatient Services</b> (Screening mammography, bone density, pap smears, proctosigmoidoscopy, sigmoidoscopy, and preventative colonoscopies are covered in full)	\$40 Co-pay Same Day Surgery \$60 Co-pay	10% of billed charges or \$75 (whichever is greater) up to a combined annual inpatient/ outpatient combined coinsurance maximum of \$3000 yourself/\$3000 Spouse/\$3000 children combined. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.
<b>Laboratory Service</b>	\$40 Co-pay	10% of billed charges or \$75 (whichever is greater) up to a combined annual inpatient/ outpatient combined coinsurance maximum of \$3000 yourself/\$3000 Spouse/\$3000 children combined. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.
<b>Pre-Admission Testing</b> <i>(prior to an inpatient admission)</i>	Covered in Full	10% of billed charges or \$75 (whichever is greater) up to a combined annual inpatient/ outpatient combined coinsurance maximum of \$3000 yourself/\$3000 Spouse/\$3000 children combined. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.



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### HOSPITAL SERVICES (CONT.)

#### **Emergency Room**

*Note: In case of a medical emergency: Paid-in-full benefits for attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram exams, and/or pathology services. This benefit applies to the in and out of network benefits. For other participating specialty physicians, benefits will be paid in full. For other non-participating specialty physicians, benefits will be considered under the out of network benefits and not subject to deductible and coinsurance.*

\$70 Co-pay. Co-pay is waived if the patient is admitted to an inpatient setting in the hospital for an injury or the sudden onset of a medical or behavioral condition. The symptoms of an emergency condition (e.g. severe pain) must be serious enough that a layperson with average knowledge of medicine and health could reasonably believe that, if not immediately treated;

- The person's health, or, in the case of a behavioral condition the person's health or the health of others, could reasonably be in danger;
- The person's bodily functions could be seriously impaired
- One of the organs or other parts of the body could be harmed; or
- The person could be seriously disfigured

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<b>Emergency Room Physicians</b>	Covered in Full	Covered in Full
<b>Physical Therapy (Inpatient Only)</b>	Covered in Full	10% of billed charges to annual inpatient/ outpatient combined coinsurance maximum of \$3000 yourself/\$3000 Spouse/\$3000 children combined.
<b>Physical Therapy (Outpatient)</b>	\$20 Co-pay	10% of billed charges or \$75 (whichever is greater) up to a combined annual inpatient/ outpatient combined coinsurance maximum of \$3000 yourself/\$3000 Spouse/\$3000 children combined. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.
<b>Chemotherapy/Hemodialysis</b>	Covered in Full	10% of billed charges or \$75 (whichever is greater) up to a combined annual inpatient/ outpatient combined coinsurance maximum of \$3000 yourself/\$3000 Spouse/\$3000 children combined. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.
<b>Ambulatory Surgical Centers</b>	\$30 Co-pay	80% of Medicare allowance after deductible



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### PHYSICIAN SERVICES

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<b>Physician Office Visits</b>	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible
<b>Specialist Office Visits</b>	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible
<b>Gynecology Office Visits</b> (Covered in full for routine exam)	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible
<b>Diagnostic Tests &amp; X-Ray</b> (mammography screening covered in full)	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible
<b>Laboratory Services</b> (Free-standing Lab covered in Full)	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible
<b>Well Baby/Child Care (up to age 19)</b> (Including Immunizations) (Gardasil is covered for male & female ages 19-26)	Covered in Full	80% of Medicare allowance after deductible
<b>Routine Adult Physical Exam</b> <i>including influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chickenpox), tetanus immunizations, Hepatitis A, Hepatitis B, Human Papillomavirus (HPV) immunizations (covered for enrollees and dependents age 19 through 26), meningitis immunizations and Herpes Zoster (Shingles) immunization for enrollees and dependents age 60 or older. Herpes Zoster (Shingles) immunization is covered subject to a \$20 copayment for enrollees age 55 and over but under age 60. The copayment also covers the cost of oral and injectable substances received from a participating provider.</i>	Covered in Full Including Immunizations listed All other immunizations will be paid less a co-pay	100% of covered expenses Immunizations are not covered
<b>Surgery</b>	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible
<b>Anesthesiology</b>	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible



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### PHYSICIAN SERVICES –Continued

<b>Allergy Testing</b>	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible
<b>Allergy Treatment</b>	Covered in Full	80% of Medicare allowance after deductible
<b>Chiropractic Services</b> <i>Requires prior authorization</i> Modalities not covered	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	50% of Medicare allowance after satisfaction of \$250 physical medicine deductible
<b>Physical, Occupational &amp; Speech Therapy</b> <i>Requires prior authorization</i> <i>Must start 6 months from hospital discharge or surgery. No payments made after 365 days from the date of discharge or surgery</i>	\$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	50% of Medicare allowance after satisfaction of \$250 physical medicine deductible
<b>Durable Medical Equipment</b> <i>Requires prior authorization</i>	Covered in Full	50% of Medicare allowance after satisfaction of \$250 physical medicine deductible

### OTHER BENEFITS

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<b>Hospice Care</b> <i>Pre-Certification is required</i>	Covered in Full	10% of billed charges to annual inpatient/ outpatient combined coinsurance maximum of \$3000 yourself/\$3000 Spouse/\$3000 children combined. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.
<b>Skilled Nursing Facility</b> <i>Pre-Certification is required</i>	Covered in Full to the Medicare Limit	10% of billed charges to annual inpatient/ outpatient combined coinsurance maximum of \$3000 yourself/\$3000 Spouse/\$3000 children combined. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.
<b>Home Health Care</b> <i>Pre-certification is required</i> Custodial Care is not covered	Covered in Full	1 <sup>st</sup> 48 hours not covered, then 50% of Medicare allowance after satisfaction of deductible



## TOWN OF NORTH HEMPSTEAD ISLAND 65 BENEFIT SUMMARY

### OTHER BENEFITS - Continued

#### **Prostheses and Orthotics**

*Wigs are covered up to a \$1,500 lifetime maximum when hair loss is due to a chronic or acute condition. This benefit is not subject to deductible or coinsurance.*

*External Mastectomy Prostheses are covered one single or double once per calendar year. Pre-certification is required for any prostheses over \$1,000. This benefit is not subject to deductible or coinsurance.*

Covered in Full

80% of Medicare allowance after deductible

#### **Ambulance** (local professional)

*Volunteer ambulance covered in full up to \$50 under 50 miles and \$75 over 50 miles*

\$35 Co-pay

\$35 Co-pay

#### **Hearing Aid**

Paid at 100% up to a total maximum reimbursement of \$1,500 per ear once in any 48 months. Children of age 12 and under are covered to a total maximum reimbursement of \$1,500 per ear once every two years. These benefits are not subject to deductible or co-insurance

### MENTAL HEALTH / SUBSTANCE ABUSE SERVICES

#### IN-NETWORK BENEFIT PAYMENT

#### OUT-OF-NETWORK BENEFIT PAYMENT

#### **Substance Abuse Inpatient**

*Pre-Certification of the admission is required*

Covered in Full

10% of billed charges to annual inpatient/  
outpatient combined coinsurance maximum  
of \$3000 yourself/\$3000 Spouse/\$3000  
children combined

#### **Substance Abuse Outpatient**

\$20 Co-pay per date of service  
per type of procedure. Maximum  
of 2 copayments

80% of covered expense after deductible

#### **Mental Health Inpatient**

*Pre-Certification of the admission is required*

Covered in Full

10% of billed charges to annual inpatient/  
outpatient combined coinsurance maximum  
of \$3000 yourself/\$3000 Spouse/\$3000  
children combined

#### **Mental Health Outpatient**

\$20 Co-pay per date of service  
per type of procedure. Maximum  
of 2 copayments

80% of Medicare allowance after deductible



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### PRESCRIPTION DRUGS

**Prescription Drug Benefit**

When you fill a prescription for certain maintenance medications, your first two fills will be limited to up to a 30-day supply if you have not used your Island Group coverage during the past 180-day period. Remaining refills may be dispensed for up to a 90-day supply.

Up to 30 day supply at retail or mail order pharmacy

Generic Drugs	\$5
Preferred Brand Name Drugs	\$25
Non-Preferred Brand Name Drugs	\$45 plus the difference between the Generic and Brand

31-90 day supply at retail pharmacy

Generic Drugs	\$10
Preferred Brand Name Drugs	\$50
Non-Preferred Brand Name Drugs	\$90 plus the difference between the Generic and Brand

31-90 day supply at mail order pharmacy

Generic Drugs	\$5
Preferred Brand Name Drugs	\$50
Non-Preferred Brand Name Drugs	\$90 plus the difference between the Generic and Brand