WILLIAM FLOYD U.F.S.D. ISLAND 65 BENEFIT SUMMARY

GENERAL CONDITIONS

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

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

HOSPITAL SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Hospital Inpatient Services *Precertification required* (Including 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.
Hospital Outpatient Services (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.
Laboratory Service	$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.
Pre-Admission Testing *(prior to an inpatient admission)*	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

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Emergency Room Physicians	Covered in Full	Covered in Full
Physical Therapy (Inpatient Only)	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.
Physical Therapy (Outpatient)	$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.
Chemotherapy/Hemodialysis/ Radiation Therapy	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.
Ambulatory Surgical Centers Screening proctosigmoidoscopy, sigmoidoscopy, and colonoscopies are covered in full	$30 Co-pay	80% of Medicare allowance after deductible

ISLAND GROUP ADMINISTRATION, INC.
ISLAND GROUP

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PHYSICIAN SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Physician Office Visits	$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible
Specialist Office Visits	$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible
Gynecology Office Visits (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
Diagnostic Tests & X-Ray (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
Laboratory Services (Freestanding 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
Routine Adult Physical Exam *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.*	Covered in Full Including Immunizations listed. All other immunizations will be paid less a co-pay	100% of Medicare allowance Immunizations are not covered
Surgery	**In Office** $20 Co-pay per date of service per type of procedure. Maximum of 2 copayments **In Facility** Covered in Full	80% of Medicare allowance after deductible
Anesthesiology	**In Office** $20 Co-pay per date of service per type of procedure. Maximum of 2 copayments **In Facility** Covered in Full	80% of Medicare allowance after deductible
Allergy Treatment	Covered in Full	80% of Medicare allowance after deductible
Chiropractic Services *Requires prior authorization* Modalities not covered	$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	50% network allowance after satisfaction of $250 physical medicine deductible

WILLIAM FLOYD U.F.S.D. ISLAND 65 BENEFIT SUMMARY

PHYSICIAN SERVICES –Continued

Physical, Occupational & Speech Therapy *Requires prior authorization* *Must start 6 months from hospital discharge or surgery. No payments made after 365 days from the date of discharge or surgery*	$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	50% network allowance after satisfaction of $250 physical medicine deductible
Durable Medical Equipment *Requires prior authorization*	Covered in Full	50% of network allowance after satisfaction of deductible

OTHER BENEFITS

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Hospice Care *Pre-Certification is required*	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.
Skilled Nursing Facility *Pre-Certification is required*	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.
Home Health Care *Pre-certification is required* Custodial Care is not covered	Covered in Full	1st 48 hours not covered, then 50% network allowance after satisfaction of deductible
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
Emergency 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	

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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. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.
Substance Abuse Outpatient	$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance 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. When the coinsurance maximum has been satisfied you will receive network benefits subject to all applicable copayments.
Mental Health Outpatient	$20 Co-pay per date of service per type of procedure. Maximum of 2 copayments	80% of Medicare allowance after deductible

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