Benefit Summary

AvMed Embrace better health.

MEDICARE ELIGIBLE RETIREE HIGH OPTION WITHOUT PRESCRIPTION DRUG COVERAGE

JACKSON HEALTH SYSTEM	SCHEDULE OF BENEFITS
LIFETIME MAXIMUM	Unlimited
DEDUCTIBLE AMOUNT PER CALENDAR YEAR Per Individual	$198 for Private Duty Nursing $250 for Foreign Travel Emergency Care
CHOICE OF HOSPITALS	Unlimited
MEDICARE PART B DEDUCTIBLE: $198 PER CALENDAR YEAR	Not Covered
INPATIENT HOSPITAL FACILITY *Covered by Medicare Part A.* Medicare covers: ***Days 1—60**:* *All but $1,408* ***Days 61—90**:* *All but $352 per day* ***Days 91—150:*** *All but $704 per day* **Days 91—150 are the 60 Lifetime Reserve Days. Medicare will cease until a new Benefit Period begins. A new Benefit Period begins after you have been out of the hospital or facility for at least 60 days. In a new Benefit Period, all Medicare Part A will renew except for the Lifetime Reserve Days.*	100% up to $1,408 100% up to $352 per day 100% up to $704 per day *365 additional lifetime days after Medicare Lifetime Reserve Days are exhausted Covered at 100% of Medicare eligible expense Must be Medically Necessary Limiting semi-private room (unless Medically Necessary) & board amount
HOSPITAL OUTPATIENT/PHYSICIAN *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
SKILLED NURSING FACILITIES *Days 1—20: Covered by Medicare Part A* *Days 21—100: Covered all but $176 per day* *Days 101 & beyond: all costs*	Days 1—20: Not Covered Days 21—100: 100% up to $176 per day Days 101 & beyond: Not Covered
PHYSICIAN VISITS/ILLNESS *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
EMERGENCY AND URGENT CARE SERVICES *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
PHYSICIAN'S OFFICE VISIT *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
SPECIALIST'S OFFICE VISIT *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
SURGICAL PROCEDURES *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
PREVENTIVE CARE *Covered by Medicare Part B* Includes, but is not limited to: Annual Screening Mammogram Pap Smear & Pelvic Exam Bone Mass Measurement Prostate Cancer Screening Physical Exam (Yearly "Wellness" Exam) Colorectal Screening *Subject to Preventive Care guidelines outlined in the "2020 Medicare & You" publication from Centers for Medicare & Medicaid Services (CMS)*	No Charge

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ALLERGY INJECTIONS *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
DURABLE MEDICAL EQUIPMENT *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
IMMUNIZATIONS *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
X-RAYS *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
ADVANCED RADIOLOGICAL IMAGING (I.E. MRIs, MRAs, CAT Scans and PET Scans) *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
PHYSICAL THERAPY SERVICES *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
TMJ Surgical and Non-Surgical *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
OTHER LAB/RADIOLOGY SERVICES *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
SHORT-TERM REHABILITATION *Covered by Medicare Part B* Includes: Cardiac Rehab Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)	Remainder 20% of Medicare approved amount
AMBULANCE *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
HOME HEALTH CARE When covered by Medicare When not covered by Medicare	No Charge Plan will pay up to $40 per visit limited to $1,600 per calendar year
FOREIGN TRAVEL/EMERGENCY CARE Not covered by Medicare	80% of Medicare approved amount after $250 calendar year deductible, up to a lifetime maximum of $50,000
PRIVATE DUTY NURSING *Covered by Medicare Part B* (*While Inpatient In a Hospital or Other Health Care Facility Only*)	80% of the Reasonable & Customary charges after $198 calendar year deductible

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JACKSON HEALTH SYSTEM	SCHEDULE OF BENEFITS
MATERNITY SERVICES *Covered by Medicare Part B* Initial Visit to confirm pregnancy All subsequent prenatal and postnatal visits *Covered by Medicare Part A* Delivery (Inpatient Hospital or Birthing Center)	 Remainder 20% of Medicare approved amount Remainder 20% of Medicare approved amount Days 1 to 60: 100% up to $1,408 Days 61 to 90: 100% up to $352 per day Days 91 -150: 100% up to $704 per day
ABORTION-NON-ELECTIVE *Covered by Medicare Part A* Inpatient	Payable as Inpatient
OUTPATIENT SURGICAL FACILITY *Covered by Medicare Part B* Surgical sterilization procedures for Vasectomy/Tubal Ligations	Remainder 20% of Medicare approved amount
BLOOD *First three pints of blood not covered by Medicare*	First three pints of blood covered at 100% of the Reasonable & Customary charges
OUTPATIENT FACILITY *Covered by Medicare Part B* Services in Operating and Recovery Room, Procedures Room and Treatment	Remainder 20% of Medicare approved amount
HOSPICE Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	Plan pays 100% of amount approved but not paid by Medicare, when Medicare certification and election requirements are met
INFERTILITY - OFFICE VISIT FOR DIAGNOSIS *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount
ORGAN TRANSPLANT *Covered by Medicare Part A*	Payable as Inpatient Hospital
EXTERNAL PROSTHESES *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount

Benefit Summary

MEDICARE ELIGIBLE RETIREE HIGH OPTION WITHOUT PRESCRIPTION DRUG COVERAGE

JACKSON HEALTH SYSTEM	SCHEDULE OF BENEFITS
MENTAL HEALTH /SUBSTANCE ABUSE INPATIENT *Covered by Medicare Part A* <u>Mental Health</u> Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 <u>Substance Abuse</u> Acute detoxification: requires 24 hour nursing; based on a ratio of 1:1 Acute Inpatient Rehab: requires 24 hour nursing; based on a ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1	Plan pays 100% of amount approved, but not paid by Medicare; if charges not approved by Medicare, there is no coverage
MENTAL HEALTH/SUBSTANCE ABUSE OUTPATIENT HOSPITAL/FACILITY *Covered by Medicare Part B*	Coverage assumes enrollment in Medicare Part B; Plan pays remainder of charges approved, but not paid by Medicare Part B, and member has $0 responsibility
EYEGLASSES *Covered by Medicare Part B*	Not Covered
PRESCRIPTION DRUG COVERAGE	Not Covered

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-844-439-5378

For specific information on benefits, exclusions and limitations
please see your Summary Plan Description (SPD).