

# Medicare Benefit Summary



## MEDICARE ELIGIBLE RETIREE HIGH OPTION WITHOUT PRESCRIPTION DRUG COVERAGE

JACKSON HEALTH SYSTEM	SCHEDULE OF BENEFITS
<b>MEDICARE PART B DEDUCTIBLE:</b>	\$257 Per Calendar Year Not Covered
<b>LIFETIME MAXIMUM</b>	Unlimited
<b>DEDUCTIBLE AMOUNT PER CALENDAR YEAR Per Individual</b>	\$257 for Private Duty Nursing – Medically Necessary \$257 for Foreign Travel Emergency Care – Medically Necessary
<b>CHOICE OF HOSPITALS</b>	Unlimited
<b>INPATIENT HOSPITAL FACILITY</b> Covered by Medicare Part A. Medicare covers: <b>Days 1—60:</b> All but \$1,676 <b>Days 61—90:</b> All but \$419 per day <b>Days 91—150:</b> All but \$838 per day  <i>*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.</i>	100% up to \$1,676 100% up to \$419 per day 100% up to \$838 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
<b>HOSPITAL OUTPATIENT/PHYSICIAN</b> Covered by Medicare Part B	Remainder 20% of Medicare approved amount
<b>SKILLED NURSING FACILITIES</b> Days 1—20: Covered by Medicare Part A Days 21—100: Covered all but \$209.50 per day Days 101 & beyond: You pay all costs	Days 1—20: Not Covered Days 21—100: 100% up to \$209.50 per day Days 101 & beyond: Not Covered
<b>PHYSICIAN VISITS/ILLNESS</b> Covered by Medicare Part B	Remainder 20% of Medicare approved amount
<b>EMERGENCY AND URGENT CARE SERVICES</b> Covered by Medicare Part B	Remainder 20% of Medicare approved amount
<b>PHYSICIAN'S OFFICE VISIT</b> Covered by Medicare Part B	Remainder 20% of Medicare approved amount
<b>SPECIALIST'S OFFICE VISIT</b> Covered by Medicare Part B	Remainder 20% of Medicare approved amount
<b>SURGICAL PROCEDURES</b> Covered by Medicare Part B	Remainder 20% of Medicare approved amount
<b>PREVENTIVE CARE</b> 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  <i>Subject to Preventive Care guidelines outlined in the "2025 Medicare &amp; You" publication from Centers for Medicare &amp; Medicaid Services (CMS)</i>	No Charge

# Medicare Benefit Summary



## MEDICARE ELIGIBLE RETIREE HIGH OPTION WITHOUT PRESCRIPTION DRUG COVERAGE

JACKSON HEALTH SYSTEM	SCHEDULE OF BENEFITS
<p><b>ACUPUNCTURE</b> (Chronic Low Back Pain) only <i>Covered by Medicare Part B</i></p> <p>Includes, but not limited to: 12 acupuncture visits in 90 days for chronic low back pain lasting 12 weeks or longer. No more than 20 Acupuncture treatments annually <b><i>Subject to additional details outlined at <a href="http://www.medicare.gov">www.medicare.gov</a>.</i></b></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>AMBULATORY SURGERY CENTERS</b> <i>Covered by Medicare Part B</i> <i>*Facility where surgical procedures are performed, and you're expected to be released within 24 hours.</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>MEDICARE TELEHEALTH, E-VISITS, AND VIRTUAL CHECK-INS</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>ALLERGY INJECTIONS</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>DURABLE MEDICAL EQUIPMENT</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>IMMUNIZATIONS</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>X-RAYS</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>ADVANCED RADIOLOGICAL IMAGING (I.E. MRIs, MRAs, CAT Scans and PET Scans)</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>PHYSICAL THERAPY SERVICES</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>TMJ Surgical and Non-Surgical</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>OTHER LAB/RADIOLOGY SERVICES</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>SHORT-TERM REHABILITATION</b> <i>Covered by Medicare Part B</i></p> <p><u>Includes:</u> Cardiac Rehab Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)</p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>AMBULANCE</b> <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>

# Medicare Benefit Summary



## MEDICARE ELIGIBLE RETIREE HIGH OPTION WITHOUT PRESCRIPTION DRUG COVERAGE

JACKSON HEALTH SYSTEM	SCHEDULE OF BENEFITS
<p><b>HOME HEALTH CARE</b>  <i>Covered by Medicare Part A</i>                      When covered by Medicare                      When not covered by Medicare</p>	<p>No Charge                      Plan will pay up to \$40 per visit limited to \$1,600 per calendar year</p>
<p><b>FOREIGN TRAVEL/EMERGENCY CARE</b>  <i>Not covered by Medicare Part A</i>  <i>Covered by Medicare Part B – Medically Necessary</i></p>	<p>80% of Medicare approved amount after \$257 calendar year deductible, up to a lifetime maximum of \$50,000</p>
<p><b>PRIVATE DUTY NURSING</b>  <i>Medicare Part A</i>  <i>Covered by Medicare Part B – Medically Necessary (While Inpatient In a Hospital or Other Health Care Facility Only)</i></p>	<p>Not Covered                      80% of the Reasonable &amp; Customary charges after \$257 calendar year deductible</p>
<p><b>MATERNITY SERVICES</b>  <i>Covered by Medicare Part B</i>                      Initial Visit to confirm pregnancy                       All subsequent prenatal and postnatal visits   <i>Covered by Medicare Part A</i>                      Delivery (Inpatient Hospital or Birthing Center)</p>	<p>Remainder 20% of Medicare approved amount                       Remainder 20% of Medicare approved amount                       Days 1 to 60: 100% up to \$1,676                      Days 61 to 90: 100% up to \$419 per day                      Days 91 -150: 100% up to \$838 per day</p>
<p><b>ABORTION-NON-ELECTIVE</b>  <i>Covered by Medicare Part A</i>                      Inpatient</p>	<p>Payable as Inpatient</p>
<p><b>OUTPATIENT SURGICAL FACILITY</b>  <i>Covered by Medicare Part B</i>                      Surgical sterilization procedures for Vasectomy/Tubal Ligations</p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>BLOOD</b>  <i>First three pints of blood not covered by Medicare</i></p>	<p>First three pints of blood covered at 100% of the Reasonable &amp; Customary charges</p>
<p><b>OUTPATIENT FACILITY</b>  <i>Covered by Medicare Part B</i>                      Services in Operating and Recovery Room, Procedures Room and Treatment</p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>HOSPICE</b>  <i>Covered by Medicare Part A</i>                      Inpatient Services                      Outpatient Services (same coinsurance level as Home Health Care)</p>	<p>Plan pays 100% of amount approved but not paid by Medicare, when Medicare certification and election requirements are met</p>
<p><b>INFERTILITY - OFFICE VISIT FOR DIAGNOSIS</b>  <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>ORGAN TRANSPLANT</b>  <i>Covered by Medicare Part A</i></p>	<p>Payable as Inpatient Hospital</p>
<p><b>EXTERNAL PROSTHESES</b>  <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>

# Medicare Benefit Summary



## MEDICARE ELIGIBLE RETIREE HIGH OPTION WITHOUT PRESCRIPTION DRUG COVERAGE

JACKSON HEALTH SYSTEM	SCHEDULE OF BENEFITS
<p><b>MENTAL HEALTH /SUBSTANCE ABUSE INPATIENT</b>  <i>Covered by Medicare Part A</i></p> <p><u>Mental Health</u>                      Acute: based on ratio of 1:1</p> <p>Partial: based on a ratio of 2:1</p> <p><u>Substance Abuse</u>                      Acute detoxification: requires 24 hour nursing; based on a ratio of 1:1</p> <p>Acute Inpatient Rehab: requires 24 hour nursing; based on a ratio of 1:1</p> <p>Partial: based on a ratio of 2:1</p> <p>Residential: based on a ratio of 2:1</p>	<p>Plan pays 100% of amount approved, but not paid by Medicare; if charges not approved by Medicare, there is no coverage</p>
<p><b>MENTAL HEALTH/SUBSTANCE ABUSE OUTPATIENT HOSPITAL/FACILITY</b>  <i>Covered by Medicare Part B</i></p>	<p>Coverage assumes enrollment in Medicare Part B 20% of Medicare approved amount; Plan pays remainder of charges approved, but not paid by Medicare Part B, and member has \$0 responsibility.                      \$0 cost for yearly depression screening</p>
<p><b>PARTIAL HOSPITALIZATION MENTAL HEALTH CARE</b>  <i>Covered by Medicare Part B</i></p>	<p>Remainder of 20% Medicare approved amount coinsurance each day for partial hospitalization services you get in a hospital outpatient setting or community mental health center</p>
<p><b>EYEGLASSES</b>  <i>Covered by Medicare Part B</i></p>	<p>Not Covered</p>
<p><b>PRESCRIPTION DRUG COVERAGE</b>  <i>Not Covered by Medicare Part D</i></p>	<p>Not Covered</p>

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

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