Benefit Summary

MEDICARE ELIGIBLE RETIREE HIGH OPTION WITH 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 *Covered by Medicare Part B* Surgical and Non-Surgical	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

Benefit Summary

AvMed Embrace better health.

MEDICARE ELIGIBLE RETIREE HIGH OPTION WITH PRESCRIPTION DRUG COVERAGE

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

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MEDICARE ELIGIBLE RETIREE HIGH OPTION WITH 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	
Retail (30-day supply)	80% after $200 calendar year deductible
Specialty (30-day supply at Participating Specialty Pharmacy)	$100 copayment per prescription for Specialty drugs
Mail Order (90-day supply at Participating Pharmacy)	100% after $10 copayment for Generic 100% after $20 copayment for Preferred Brand 100% after $30 copayment for Non-Preferred Brand
Mail Order at Non-Participating Pharmacy	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).