Benefit Summary

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE HIGH OPTION PLANS FOR JACKSON HEALTH SYSTEM

BENEFIT HIGHLIGHTS	HIGH WITH RX	HIGH W/O RX
LIFETIME MAXIMUM	Unlimited	Unlimited
DEDUCTIBLE AMOUNT PER CALENDAR YEAR Per Individual	$198 for Private Duty Nursing $250 for Foreign Travel Emergency Care	$198 for Private Duty Nursing $250 for Foreign Travel Emergency Care
CHOICE OF HOSPITALS	Unlimited	Unlimited
MEDICARE PART B DEDUCTIBLE: $198 PER CALENDAR YEAR	Not Covered	Not Covered
INPATIENT HOSPITAL FACILITY *Covered by Medicare Part A. Medicare covers:* ***Days 1 to 60**: All but $1,408* ***Days 61 to 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	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
HOSPITAL OUTPATIENT/PHYSICIAN *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount	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: Up to $176 per day Days 101 & beyond: Not Covered	Days 1 - 20: Not Covered Days 21 - 100: Up to $176 per day Days 101 & beyond: Not Covered
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)*	No Charge	No Charge

Benefit Summary

AvMed Embrace better health.

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE HIGH OPTION PLANS FOR JACKSON HEALTH SYSTEM

BENEFIT HIGHLIGHTS	HIGH WITH RX	HIGH W/O RX
PHYSICIAN VISITS/ILLNESS *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
DURABLE MEDICAL EQUIPMENT *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
X-RAYS *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
PHYSICAL THERAPY SERVICES *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount	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	Remainder 20% of Medicare approved amount
AMBULANCE *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount	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	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 covered expenses after $250 calendar year deductible, up to a lifetime maximum of $50,000	80% of covered expenses after $250 calendar year deductible, up to a lifetime maximum of $50,000

Benefit Summary

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE HIGH OPTION PLANS FOR JACKSON HEALTH SYSTEM

BENEFIT HIGHLIGHTS	HIGH WITH RX	HIGH W/O RX
PRIVATE DUTY NURSING *Covered by Medicare Part B* (While Inpatient in a Hospital or Other Health Care Facility only)	80% of Reasonable & Customary charges after $198 calendar year deductible	80% of Reasonable & Customary charges after $198 calendar year deductible
BLOOD *First three pints of blood not covered by Medicare*	First three pints of blood covered at 100% of Reasonable & Customary charges	First three pints of blood covered at 100% of Reasonable & Customary charges
ROUTINE FOOT DISORDERS *Covered by Medicare Part B*	Not covered except for services associated with foot care for diabetes and peripheral vascular disease	Not covered except for services associated with foot care for diabetes and peripheral vascular disease
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	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	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

Benefit Summary

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MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE LOW AND HIGH OPTION PLANS FOR JACKSON HEALTH SYSTEM

BENEFIT HIGHLIGHTS	HIGH WITH RX	HIGH W/O RX
MATERNITY SERVICES		
Covered by Medicare Part B Initial Visit to confirm pregnancy	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
Physician's Office Visits in addition to the global maternity fee when performed by an OB or Specialist	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
Covered by Medicare Part A Delivery - Facility (Inpatient Hospital, Birthing Center)	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	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
EYEGLASSES *Covered by Medicare Part B*	Not Covered	Not Covered
PRESCRIPTION DRUG COVERAGE		
Retail (30-day supply)	80% after $200 calendar year deductible	Not Covered
Specialty (30-day supply at Participating Specialty Pharmacy)	100% after $100 copayment	Not Covered
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	Not Covered
Mail Order at Non-Participating Pharmacy	Not Covered	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).