

Medicare Benefit Summary



MEDICARE ELIGIBLE RETIREE HIGH OPTION WITHOUT PRESCRIPTION DRUG COVERAGE

JACKSON HEALTH SYSTEM	SCHEDULE OF BENEFITS
MEDICARE PART B DEDUCTIBLE:	\$240 Per Calendar Year Not Covered
LIFETIME MAXIMUM	Unlimited
DEDUCTIBLE AMOUNT PER CALENDAR YEAR Per Individual	\$240 for Private Duty Nursing – Medically Necessary \$250 for Foreign Travel Emergency Care
CHOICE OF HOSPITALS	Unlimited
INPATIENT HOSPITAL FACILITY Covered by Medicare Part A. Medicare covers: Days 1—60: All but \$1,632 Days 61—90: All but \$408 per day Days 91—150: All but \$816 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 \$1,632 100% up to \$408 per day 100% up to \$808160 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 \$204 per day Days 101 & beyond: You pay all costs	Days 1—20: Not Covered Days 21—100: 100% up to \$204 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 <i>Subject to Preventive Care guidelines outlined in the "2024 Medicare & You" publication from Centers for Medicare & Medicaid Services (CMS)</i>	No Charge

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<p>ACUPUNCTURE (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 <i>Subject to additional details outlined at www.medicare.gov.</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>AMBULATORY SURGERY CENTERS <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>MEDICARE TELEHEALTH, E-VISITS, AND VIRTUAL CHECK-INS <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>ALLERGY INJECTIONS <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>DURABLE MEDICAL EQUIPMENT <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>IMMUNIZATIONS <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>X-RAYS <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>ADVANCED RADIOLOGICAL IMAGING (I.E. MRIs, MRAs, CAT Scans and PET Scans) <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>PHYSICAL THERAPY SERVICES <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>TMJ Surgical and Non-Surgical <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>OTHER LAB/RADIOLOGY SERVICES <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>SHORT-TERM REHABILITATION <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>AMBULANCE <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>

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<p>HOME HEALTH CARE When covered by Medicare</p> <p>When not covered by Medicare</p>	<p>No Charge</p> <p>Plan will pay up to \$40 per visit limited to \$1,600 per calendar year</p>
<p>FOREIGN TRAVEL/EMERGENCY CARE Not covered by Medicare</p>	<p>80% of Medicare approved amount after \$250 calendar year deductible, up to a lifetime maximum of \$50,000</p>
<p>PRIVATE DUTY NURSING <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</p> <p>80% of the Reasonable & Customary charges after \$240 calendar year deductible</p>
<p>MATERNITY SERVICES <i>Covered by Medicare Part B</i> Initial Visit to confirm pregnancy</p> <p>All subsequent prenatal and postnatal visits</p> <p><i>Covered by Medicare Part A</i> Delivery (Inpatient Hospital or Birthing Center)</p>	<p>Remainder 20% of Medicare approved amount</p> <p>Remainder 20% of Medicare approved amount</p> <p>Days 1 to 60: 100% up to \$1,632 Days 61 to 90: 100% up to \$408 per day Days 91 -150: 100% up to \$816 per day</p>
<p>ABORTION-NON-ELECTIVE <i>Covered by Medicare Part A</i> Inpatient</p>	<p>Payable as Inpatient</p>
<p>OUTPATIENT SURGICAL FACILITY <i>Covered by Medicare Part B</i> Surgical sterilization procedures for Vasectomy/Tubal Ligations</p>	<p>Remainder 20% of Medicare approved amount</p>
<p>BLOOD <i>First three pints of blood not covered by Medicare</i></p>	<p>First three pints of blood covered at 100% of the Reasonable & Customary charges</p>
<p>OUTPATIENT FACILITY <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>HOSPICE 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>INFERTILITY - OFFICE VISIT FOR DIAGNOSIS <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>
<p>ORGAN TRANSPLANT <i>Covered by Medicare Part A</i></p>	<p>Payable as Inpatient Hospital</p>
<p>EXTERNAL PROSTHESES <i>Covered by Medicare Part B</i></p>	<p>Remainder 20% of Medicare approved amount</p>

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<p>MENTAL HEALTH /SUBSTANCE ABUSE INPATIENT <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>MENTAL HEALTH/SUBSTANCE ABUSE OUTPATIENT HOSPITAL/FACILITY <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 for yearly depression screening</p>
<p>PARTIAL HOSPITALIZATION MENTAL HEALTH CARE <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>EYEGLASSES <i>Covered by Medicare Part B</i></p>	<p>Not Covered</p>
<p>PRESCRIPTION DRUG COVERAGE</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).