

Medicare Benefit Summary



MEDICARE ELIGIBLE RETIREE HIGH OPTION WITH PRESCRIPTION DRUG COVERAGE

MIAMI-DADE COUNTY	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
<p>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</p> <p><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></p>	<p>100% up to \$1,632 100% up to \$408 per day 100% up to \$816 per day</p> <p>*365 additional lifetime days after Medicare Lifetime Reserve Days are exhausted</p> <p>Covered at 100% of Medicare eligible expense</p> <p>Must be Medically Necessary</p> <p>Limiting semi-private room (unless Medically Necessary) & board amount</p>
<p>HOSPITAL OUTPATIENT/PHYSICIAN Covered by Medicare Part B</p>	Remainder 20% of Medicare approved amount
<p>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</p>	<p>Days 1—20: Not Covered Days 21—100: 100% up to \$204 per day Days 101 & beyond: Not Covered</p>
<p>PHYSICIAN VISITS/ILLNESS Covered by Medicare Part B</p>	Remainder 20% of Medicare approved amount
<p>EMERGENCY AND URGENT CARE SERVICES Covered by Medicare Part B</p>	Remainder 20% of Medicare approved amount
<p>PHYSICIAN'S OFFICE VISIT Covered by Medicare Part B</p>	Remainder 20% of Medicare approved amount
<p>SPECIALIST'S OFFICE VISIT Covered by Medicare Part B</p>	Remainder 20% of Medicare approved amount
<p>SURGICAL PROCEDURES Covered by Medicare Part B</p>	Remainder 20% of Medicare approved amount
<p>PREVENTIVE CARE Covered by Medicare Part B</p> <p>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</p> <p><i>Subject to Preventive Care guidelines outlined in the "2024 Medicare & You" publication from Centers for Medicare & Medicaid Services (CMS).</i></p>	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 <i>Covered by Medicare Part B</i> Surgical and Non-Surgical</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>Includes: 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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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 <i>Medicare Part A</i> Covered by Medicare Part B – Medically Necessary (While Inpatient In a Hospital or Other Health Care Facility Only)	Not Covered 80% of the Reasonable & Customary charges after \$240 calendar year deductible
MATERNITY SERVICES Covered by Medicare Part B Initial Visit to confirm pregnancy All subsequent prenatal and postnatal visits <i>Covered by Medicare Part A</i> 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 \$1,632 Days 61 to 90: 100% up to \$408 per day Days 91-150: 100% up to \$816 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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<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 20% of Medicare approved amount Coinsurance each day for partial hospitalization services you get in a hospital outpatient setting or community mental health center</p>
<p>EYEGASSES <i>Covered by Medicare Part B</i></p>	<p>Not Covered</p>
<p>PRESCRIPTION DRUG COVERAGE</p> <p>Retail (30-day supply)</p> <p>Specialty (30-day supply at Participating Specialty Pharmacy)</p> <p>Mail Order (90-day supply at Participating Pharmacy)</p> <p>Mail Order at Non-Participating Pharmacy</p>	<p>80% after \$200 calendar year deductible</p> <p>\$100 copayment per prescription for Specialty drugs</p> <p>100% after \$10 copayment for Generic 100% after \$20 copayment for Preferred Brand 100% after \$30 copayment for Non-Preferred Brand</p> <p>Not Covered</p>

FOR ADDITIONAL INFORMATION, PLEASE CALL: 800-68-AVMED (1-800-682-8633)

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