Benefit Summary

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE LOW AND HIGH OPTION PLANS FOR MIAMI-DADE COUNTY

BENEFIT HIGHLIGHTS	LOW	HIGH WITH RX	HIGH W/O RX
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited
DEDUCTIBLE AMOUNT PER CALENDAR YEAR Per Individual	$147 for certain benefits **only** (Private Duty Nursing and Blood)	$147 for Private Duty Nursing $250 for Foreign Travel Emergency Care	$147 for Private Duty Nursing $250 for Foreign Travel Emergency Care
CHOICE OF HOSPITALS	Unlimited	Unlimited	Unlimited
MEDICARE PART B DEDUCTIBLE: $147 PER CALENDAR YEAR	Not Covered	Not Covered	Not Covered
INPATIENT HOSPITAL FACILITY *Covered by Medicare Part A. Medicare covers:* ***Days 1 to 60**: All but $1,260* ***Days 61 to 90**: All but $315 per day* ***Days 91 -150*:** *All but $630 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 $1,260 100% up to $315 per day 100% up to $630 per day *No additional Reserve Days	100% up to $1,260 100% up to $315 per day 100% up to $630 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 $1,260 100% up to $315 per day 100% up to $630 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 for these services only: Physician hospital visits (inpatient/outpatient) Surgical services (inpatient/outpatient) Anesthesia services (inpatient/outpatient)	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 $157.50 per day.*	Not Covered	Days 1 - 20: Not Covered Days 21 - 100: Up to $157.50 per day	Days 1 - 20: Not Covered Days 21 - 100: Up to $157.50 per day

Benefit Summary

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE LOW AND HIGH OPTION PLANS FOR MIAMI-DADE COUNTY

BENEFIT HIGHLIGHTS	LOW	HIGH WITH RX	HIGH W/O RX
PHYSICIAN VISITS/ILLNESS *Covered by Medicare Part B*	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
DURABLE MEDICAL EQUIPMENT *Covered by Medicare Part B*	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
X-RAYS *Covered by Medicare Part B*	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
PHYSICAL THERAPY SERVICES *Covered by Medicare Part B*	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
SHORT-TERM REHABILITATION *Covered by Medicare Part B* <u>Includes:</u> Cardiac Rehab Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)	Not Covered	Remainder 20% of Medicare approved amount Limited to $1,940 per calendar year for Physical Therapy (PT) and Speech Therapy Language Pathology (SLP) services combined Limited to $1,940 per calendar year for Occupational Therapy (OT) services	Remainder 20% of Medicare approved amount Limited to $1,940 per calendar year for Physical Therapy (PT) and Speech Therapy Language Pathology (SLP) services combined Limited to $1,940 per calendar year for Occupational Therapy (OT) services
AMBULANCE *Covered by Medicare Part B*	Not Covered	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 Not Covered	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*	Not Covered	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 LOW AND HIGH OPTION PLANS FOR MIAMI-DADE COUNTY

BENEFIT HIGHLIGHTS	LOW	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 $147 calendar year deductible Lifetime maximum $10,000 combined with blood and blood products	80% of Reasonable & Customary charges after $147 calendar year deductible	80% of Reasonable & Customary charges after $147 calendar year deductible
BLOOD *First three pints of blood not covered by Medicare*	First three pints of blood covered at 80% of Reasonable & Customary charges after $147 calendar year deductible Lifetime maximum of $10,000 combined with Private Duty Nursing	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	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	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.	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

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE LOW AND HIGH OPTION PLANS FOR MIAMI-DADE COUNTY

BENEFIT HIGHLIGHTS	LOW	HIGH WITH RX	HIGH W/O RX
MATERNITY SERVICES			
Covered by Medicare Part B Initial Visit to confirm pregnancy	Not Covered	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)	Not Covered	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	Not Covered	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 $1,260 Days 61 to 90: 100% up to $315 per day Days 91 -150: 100% up to $630 per day	Days 1 to 60: 100% up to $1,260 Days 61 to 90: 100% up to $315 per day Days 91 -150: 100% up to $630 per day	Days 1 to 60: 100% up to $1,260 Days 61 to 90: 100% up to $315 per day Days 91 -150: 100% up to $630 per day
EYEGLASSES *Covered by Medicare Part B*	Not Covered	Not Covered	Not Covered
PRESCRIPTION DRUG COVERAGE			
Retail (30-day supply)	80% after $200 calendar year deductible	80% after $200 calendar year deductible	Not Covered
Specialty (30-day supply at Participating Specialty Pharmacy)	100% after $100 co-payment	100% after $100 co-payment	Not Covered
Mail Order (90-day supply at participating pharmacy)	100% after $10 co-payment for Generic; 100% after $20 co-payment for Preferred Brand; 100% after $30 co-payment for Non-Preferred Brand	100% after $10 co-payment for Generic; 100% after $20 co-payment for Preferred Brand; 100% after $30 co-payment for Non-Preferred Brand	Not Covered
Mail Order at Non-Participating Pharmacy	Not Covered	Not Covered	Not Covered

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

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