2017 Medicare Benefits Chart

Medicare Part A: Hospital Covered Services

Covered Services Per Calendar Year

Service	Benefit	Medicare Pays	Balance (See NOTICE below)
Hospitalization, per benefit period[1]. Hospitalization includes semiprivate room and board, drugs, general nursing, and miscellaneous hospital services and supplies.	First 60 days	All but $1,316	$1,316
	61st to 90th day	All but $329 a day	$329 a day
	91st to 150th day[2]	All but $658 a day	$658 a day
	Beyond 150 days	Nothing	All costs
Post hospital Skilled Nursing Facility Care, per benefit period[1]. You must have been in a hospital for at least three days, enter a facility approved by Medicare within 30 days after hospital discharge, and require skilled care.	First 20 days	100% of covered services	Nothing
	Additional 80 days	All but $164.50 a day	$164.50 a day
	Beyond 100 days	Nothing	All costs
Home Healthcare Home healthcare includes part-time skilled nursing care, speech therapy, physical therapy, occupational therapy, durable medical equipment, medical supplies and other services.	Unlimited as long as you meet Medicare requirements for home healthcare benefits	Full cost of limited Medicare-approved visits; 80% for durable medical equipment	Nothing except 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	For as long as doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited cost-sharing for outpatient drugs ($5 copay) and inpatient respite care (5% coinsurance). These rates apply to hospice care outpatient drugs only. All other services are covered as described in your carrier plan.
Blood	Unlimited during a benefit period if medically necessary	All but first three pints; three-pint deductible needs to be met only once per calendar year as an inpatient and/or outpatient	Cost for first three pints

[1] A benefit period begins on the first day you are admitted to the hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.

[2] Once you have been hospitalized for 90 days, Medicare will provide you with 60 reserve days. Each reserve day can only be used once during your lifetime. Medicare will pay all but $658 per reserve day.

NOTICE:

The LACERA-administered medical plans, in general, pay the amount in the *Balance* column (above) within the benefit provisions of the plan. Medicare benefits are subject to change each year. For additional information, contact Medicare at (800) 633-4227 or visit www.medicare.gov and refer to the current *Medicare & You* Booklet.

- If you are enrolled in Anthem Blue Cross Plan I, II, or III, or Anthem Blue Cross Prudent Buyer Plan and entitled to Medicare Part A, the plan will coordinate with Medicare Part A coverage.
- If you are enrolled in Kaiser or Cigna Network Model Plan, you will be responsible for charges in excess of Medicare unless you receive treatment or authorization from your healthcare plan.
- If you are enrolled in Kaiser Senior Advantage, UnitedHealthcare Medicare Advantage, SCAN Health Plan or Cigna HealthSpring Preferred Rx (Available in Maricopa County and Apache Junction, Pinal County, Arizona Only), Medicare will not reimburse or pay for any treatment outside of your elected healthcare plan. Your plan will not cover you for treatment received outside of the plan, **except** in the event of an emergency.

(Turn over for Part B and Part D information.)

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2017 Medicare Benefits Chart

Medicare Part B: Medical Insurance

Covered Services Per Calendar Year

Service	Benefit	Medicare Pays [1]	Balance [1] (See NOTICE below)
Medical Expenses	Physicians' services, inpatient and outpatient medical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment	80% of approved amount (after $183 deductible); 100% for clinical laboratory services; certain limits may apply for physical, speech, and occupational therapy	$183 medical deductible plus 20% of balance of the approved amount
Home Healthcare (Including skilled nursing care, home health aide services, etc.)	Unlimited as long as you meet Medicare requirements	100% of approved amount for services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
Outpatient Hospital Treatment	Unlimited treatment as medically necessary	100% after a coinsurance or copay amount	A coinsurance or copay amount, which may vary according to the service
Blood	Unlimited during a benefit period if medically necessary	80% of approved amount (after first three pints and $183 deductible)	$183 deductible plus cost of first three pints plus 20% of balance of the approved amount
Preventive Services	Healthcare to prevent illness or detect illness at an early stage, when treatment is likely to work best, including the *Welcome to Medicare* preventive visit and yearly *Wellness* visit. Preventive services include Pap tests, flu shots, and screening mammograms. For a complete list of preventive services, visit www.medicare.gov	100% of coinsurance or copay amount	Nothing for covered services. However, if your doctor or other healthcare provider performs additional tests or services during the same visit that are not covered under these preventive benefits, you may have to pay coinsurance, and the $183 deductible may apply.

[1] Once you pay $183 of expenses for covered services in 2017, the Part B deductible does not apply to any further covered services you receive the rest of the year. Also, if your physician does not accept Medicare assignment, he/she may not bill you for more than 15% over Medicare's approved amount.

Part B: Monthly Premiums

Annual Income (Individual Tax Return)	2017 Monthly Premium
$0 – $85,000	$134 (base rate)
$85,001 – $107,000	$187.50
$107,001 – $160,000	$267.90
$160,001 – $214,000	$348.30
Over $214,000	$428.60

To find out what your Part B premium will be, call Social Security at (800) 772-1213. TTY users should call (800) 325-0778.

2017 Medicare Part D: Prescription Drug Coverage

Benefit	Medicare Pays	Balance (See NOTICE below)
Generic and some brand name prescription drugs purchased at a pharmacy; mail order is available for some prescription drugs.	Medicare Part D is offered through private vendors approved by Medicare. Generally, you pay a monthly premium, a copayment or coinsurance, and a deductible for your prescription drugs.	• All LACERA-administered medical plans provide prescription drug coverage. • On average, your prescription drug coverage through any LACERA-administered medical plan is as good as, if not better than, any individual Medicare Part D plan. • LACERA-administered medical plan participants **should not** enroll in non-LACERA Medicare Part D plans offered by private vendors. Contact LACERA if you have questions.

NOTICE: The LACERA-administered medical plans, in general, pay the amount in the *Balance* column within the benefit provisions of the plan. Medicare benefits are subject to change each year. For additional information, contact Medicare at (800) 633-4227 or visit www.medicare.gov and refer to the current *Medicare & You* Booklet.

- If you are enrolled in Anthem Blue Cross Plan I, II, or III, or Anthem Blue Cross Prudent Buyer Plan and entitled to Medicare Part B, the plan will coordinate with Medicare Part B coverage. The prescription drug benefits under these Anthem Blue Cross plans is equal to or better than that of Medicare Part D and is considered creditable coverage for those who are entitled to Parts A and B and are therefore eligible for Medicare Part D.
- If you are enrolled in Kaiser or Cigna Network Model Plan, you will be responsible for charges in excess of Medicare Part B unless you receive treatment or authorization from your healthcare plan; your prescription drug coverage will be through your HMO, not Medicare.
- If you are enrolled in Kaiser Senior Advantage, UnitedHealthcare Medicare Advantage, SCAN Health Plan or Cigna HealthSpring Preferred Rx (Available in Maricopa County and Apache Junction, Pinal County, Arizona Only), Medicare will not reimburse or pay for any treatment received outside of your elected healthcare plan. Your plan will not cover you for treatment received outside of the plan, **except** in the event of an emergency. Your prescription drug coverage will be through your HMO, not Medicare.

(Turn over for Part A information.)