

Summary of Signature 65 Benefits with Major Medical



Signature 65 is a Medicare-complementary benefit program that fills in the coverage gaps and cost sharing of the traditional Medicare program (Medicare Part A and Medicare Part B). In order to enroll in Signature 65, you must be enrolled in Medicare Part A and/or Medicare Part B.

Municipal Employers Insurance Trust

Medicare Part A Covered Services			
Covered Services	Medicare Pays	Plan Pays	Member Pays ^①
Inpatient Hospital Days 1-60	All but Part A Deductible	Medicare Part A Deductible	Nothing
Inpatient Hospital Days 61-90	All but Part A Coinsurance	Medicare Part A Coinsurance	Nothing
Inpatient Hospital Days 91-150 (may be used once per lifetime)	All but Part A Coinsurance	Medicare Part A Coinsurance	Nothing
Additional Inpatient Hospital Days	Nothing	100% of Medicare-eligible expenses for 365 additional days per benefit period, after the sixty (60) Medicare inpatient hospital lifetime reserve days are exhausted.	Nothing for the first 365 additional inpatient hospital days per benefit period, 100% thereafter.
Skilled Nursing Facility Days 1-20	100%	Nothing	Nothing
Skilled Nursing Facility Days 21-100	All but Part A Coinsurance	Medicare Part A Coinsurance	Nothing
Skilled Nursing Facility Days 101 and beyond	Nothing	Nothing	100%
Blood	Nothing for the first 3 pints per calendar year, 80% thereafter.	100% for the first three pints per calendar year, nothing thereafter.	Nothing for the first 3 pints per calendar year, 20% thereafter.

Medicare Part B Covered Services			
Covered Services	Medicare Pays	Plan Pays	Member Pays ^①
Most Medicare Part B Covered Services	All but the Part B Deductible and Part B Coinsurance	Medicare Part B Coinsurance	Medicare Part B Deductible
Blood	Nothing for the first 3 pints per calendar year, 80% after the Part B Deductible thereafter.	100% for the first three pints per calendar year, nothing thereafter.	Nothing for the first 3 pints per calendar year, 20% thereafter (if the Part B Deductible has been satisfied).

Major Medical Benefits (for services not covered by Medicare)	
Deductible	\$250
Plan Payment Level – Based on the provider’s reasonable charge (PRC)	80% after deductible until out-of-pocket maximum is met. Then 100%
Out-of-Pocket Maximum (Once met, plan payment level becomes 100%)	\$2,000
Lifetime Maximum	\$500,000
Physician Office Visits	80% after deductible
Preventive Care	
<i>Adult</i>	
Routine physical exams	Not Covered
Routine gynecological exams, including a PAP Test	80% (deductible does not apply)
Mammograms, as required	80% (deductible does not apply)
<i>Pediatric</i>	
Routine physical exams	Not Covered
Pediatric immunizations	80% (deductible does not apply)
Emergency Care	80% after deductible
Spinal Manipulations	80% after deductible; Limit: 20 visits/calendar year
Physical Medicine	80% after deductible; Limit: 20 visits/calendar year
Speech Therapy	80% after deductible; Limit: 20 visits/calendar year
Occupational Therapy	80% after deductible; Limit: 20 visits/calendar year
Ambulance	80% after deductible
Assisted Fertilization Procedures	Not Covered
Diagnostic Services (including routine)	80% after deductible
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)	
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Home Health Care	80% after deductible
Hospice	Not Covered
Hospital Services – Inpatient	80% after deductible
Hospital Services – Outpatient	80% after deductible
Infertility counseling, testing and treatment	80% after deductible
Maternity (facility and professional services)	80% after deductible
Medical/Surgical Expenses (except office visits)	80% after deductible
Mental Health – Inpatient ②	80% after deductible
Mental Health – Outpatient ②	50% after deductible
Private Duty Nursing	80% after deductible
Skilled Nursing Facility Care	80% after deductible
Substance Abuse – Inpatient Detoxification	80% after deductible
Substance Abuse – Inpatient Rehabilitation	80% after deductible
Substance Abuse – Outpatient	50% after deductible
Precertification Requirements ③	Performed by Member
Prescription Drugs	Not Covered

- ① If the provider does not accept assignment from Medicare, any difference between the provider’s charge and the combined Medicare/Highmark payment shall be the personal responsibility of the member.
- ② State mandated benefits (30 inpatient days and 60 outpatient visits annually with the right to exchange inpatient days for outpatient visits on a one-for-two basis) may apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa, delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see above-referenced benefits for plan limits).
- ③ Member is required to contact Highmark Health Care Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

