Santa Monica College
Comparison of PERSCare and PERS Choice for SMCFA -SMCCD Art. 10.2

Medicare Coverage

2017 Plan Year

For 2017, the following categories ARE eligible for reimbursement per 10.2.1 of the District-FA Agreement:

Check Box for each type of reimbursement	Benefit Category	Medicare PERSCare			Medicare Pers Choice			Eligible for Reimb.
		Member Pays	Comments	Covered by Plan	Member Pays	Comments	Covered by Plan	
☐	**Blood Replacement**	20%	20% Copay if not covered by Medicare	Pints #1-3 (80%)	0%	Not covered (Member pays customary charges for pints #1-3 or arranges to have blood replaced)	0	Pints #1-3 (80%)
☐	**Hearing Aid Services**	20%	Per member	$2,000/24 months	20%	Per member	$1,000/36 months	80% of PERSCare allowance minus PERS Choice allowance
☐	**Hospital (Inpatient)**	0% 20%	0-90 days *plus* reserve days (*lifetime max of 60 reserve days): No Charge 91+ days plus reserve days: 20% copay	0-90 days* 91+ days*	0% 100%	0-90 days *plus* reserve days (lifetime max of 60 reserve days): No Charge No coverage after 90 days plus reserve days	0-90 days* 0	0 80% of expenses after day 90 (plus reserve days)
☐	**Hospital (Outpatient)**	0% 20%	No charge for Medicare-approved services 20% copay for services beyond Medicare	100% 80%	0% 100%	No charge for Medicare-approved services No coverage for services beyond Medicare	100% 0	0 80% of allowed PERSCare cost
☐	**Mental Health (Inpatient)**	0% 20%	No charge for Medicare-approved services 20% copay for services beyond Medicare maximums	0-90 days* 91+ days*	0% 100%	No charge for Medicare-approved services No coverage for services beyond Medicare	100% 0	0 80% of allowed PERSCare cost
☐	**Occupational Therapy/Speech Therapy**	0% 20%	No charge up to $1,880 limit per year Expenses exceeding limit/year ($5,000 lifetime maximum for Speech Therapy)	$0.00-$1,880/yr $1,881+/yr	0% 100%	No charge up to $1,880 limit per year Expenses exceeding limit/year	$0.00-$1,880/yr $1,881+/yr	0 80% of allowed PERSCare cost/yr ($5,000 lifetime maximum for Speech Therapy)
☐	**Skilled Nursing Care**	0% 20%	1-100 days each benefit period (in a Medicare-approved facility) 101-365 days	1-100 days 80%	0% 100%	1-100 days each benefit period 101+ days	1-100 days 101+ days	0 80% of allowed cost for 101-365 days

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Medicare Coverage

2017 Plan Year

For 2017, the following categories are NOT REIMBURSABLE and are for informational purposes only:

Benefit Category	Medicare PERSCare			Medicare Pers Choice		
	Member Pays	Comments	Covered by Plan	Member Pays	Comments	Covered by Plan
Acupuncture	$15	20 visits per year	1-20 visits	$15	20 visits per year	1-20 visits
Ambulance	0%	No Charge	n/a	0%	No Charge	n/a
Biofeedback	0%	No Charge	n/a	0%	No Charge	n/a
Chiropractic	0%	No Charge	n/a	0%	No Charge	n/a
Christian Science Treatment	0%	No Charge	n/a	0%	No Charge	n/a
Diabetes Supplies	0%	Glucose monitors, test strips, lancets, etc.	n/a	0%	Glucose monitors, test strips, lancets, etc.	n/a
Diagnostic X-Ray/Laboratory	0%	No Charge	n/a	0%	No Charge	n/a
Durable Medical Equipment	0%	No Charge	n/a	0%	No Charge	n/a
Emergency Care/Services	0%	No Charge	n/a	0%	No Charge	n/a
Gynecological Exam	0%	No Charge	n/a	0%	No Charge	n/a
Heart Transplants	0%	No Charge	n/a	0%	No Charge	n/a
Home Health Services	0%	No Charge	n/a	0%	No Charge	n/a
Hospice Care	0%	No Charge	n/a	0%	No Charge	n/a
Immunization	0%	No Charge	n/a	0%	No Charge	n/a
Kidney Dialysis and Transplants	0%	No Charge	n/a	0%	No Charge	n/a
Mental Health (Outpatient)	*****	Medicare pays 50% of the approved amount for most charges.	n/a	******	Medicare pays 50% of the approved amount for most charges.	n/a
Physical Therapy	0%	No Charge	n/a	0%	No Charge	n/a
Physician Visits	0%	No Charge	n/a	0%	No Charge	n/a
Podiatrists Services	0%	No Charge	n/a	0%	No Charge	n/a
Smoking Cessation Program	20%	Up to $100 per calendar year for behavior modifying smoking cessation counseling or classes, etc.	n/a	100%	No allowance	n/a
Vision Care	*****	Any amount in excess of Max Allowance:		*****	Any amount in excess of Max Allowance:	
		Exam	$35.00		Exam	$35.00
		Frams	$30.00		Frams	$30.00
		Single Vision Lens	$20.00		Single Vision Lens	$20.00
		Bifocal Lens	$35.00		Bifocal Lens	$35.00
		Trifocal Lens	$45.00		Trifocal Lens	$45.00
		Lenticular Lens	$50.00		Lenticular Lens	$50.00
		Contact Lens	$100.00		Contact Lens	$100.00