A Guide to Understanding Medicare Benefits

Medicare is a social insurance program created under the Social Security Act of 1965 as signed by President Lyndon B. Johnson and is designed to provide a basic level of health insurance to retirees and other qualified recipients. The program is financed by payroll taxes assessed on both employees and employers (self-employed individuals pay both portions of the tax). The original Medicare program covered hospital stays and other medical treatments, but over the years the program has expanded to include alternatives to the original coverage options as well as a prescription drug plan.

Eligibility Requirements

Medicare is available to anyone over the age of 65 who is a U.S. citizen or a permanent legal resident for five continuous years. Moreover, individuals under the age of 65 may qualify if they meet one of the following requirements:

- Are permanently disabled and have received Social Security disability payments for the last two years
- Need a kidney transplant
- Are under dialysis for permanent kidney failure
- Have Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease.

Medicare Parts A and B

The original version of Medicare (Original Medicare) included two separate programs, referred to as Part A and Part B.

- ***Part A – Hospital Insurance*** covers most medically necessary hospital, skilled nursing facility, home health and hospice care. It is premium-free if you or your spouse have worked and paid Social Security taxes for at least 40 calendar quarters (10 years). A monthly premium is assessed on those with less than 40 quarters of employment. Spouses who don't have enough credits on their own work history are only eligible for premium-free Part A once the working spouse reaches age 62.
- ***Part B – Medical Insurance*** covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health care, and some home health and ambulance services. All those who are covered under Part B are assessed a monthly premium for this coverage.

Medicare Parts A and B recipients are generally responsible for 20% of most Medicare expenses plus deductibles, co-pays, and other fees, often with no cap on maximum payments. Medicare generally does not cover dental, vision, hearing, or long term care. Therefore, original Medicare is often supplemented with private insurance policies, known as Medicare Supplement or Medigap policies.

Robert W. Baird & Co. 777 East Wisconsin Avenue, Milwaukee, Wisconsin 53202. 1-800-RW-BAIRD. www.rwbaird.com
First Use: June 2011, Updated 12/2015

Medicare Supplemental (Medigap) Coverage

Medigap plans are designed to limit the out-of-pocket costs associated with original Medicare by covering some or all of the coinsurance and deductibles associated with Parts A and B. Medicare will have primary responsibility for paying a claim, but the Medigap plan usually has a crossover agreement with Medicare that allows the Medigap policy to automatically pay second. There are currently ten different standardized Medigap plans, each offering different levels of coverage and different cost structures. Prior to June 1, 2010, there were 12 different plans available, labeled by letters A through L. As of June 1, 2010, two new Medigap plans (M and N) became available, and four plans (E, H, I and J) are no longer being sold (but are still active for those who had purchased them). Not all plans are available in all states and some states may offer additional standardized plans. Massachusetts, Minnesota, and Wisconsin, do not offer the aforementioned lettered plans, but offer different standardized plans.

Each Medigap plan pays for a particular set of benefits. Plan A offers the fewest benefits and is usually the least expensive. Plans that offer more benefits are generally more expensive. Plan F is the most comprehensive and tends to be the most expensive, although there is also a high deductible version of that plan which helps lower premium costs.

Medicare Part D

Medicare Part D is the part of Medicare that provides outpatient prescription drug coverage and is provided through private insurance companies that have contracts with Medicare. Part D coverage is optional, and purchasing the coverage should be based on the enrollee's individual needs. However, if you do not enroll when you are first required to, you will pay a late enrollment penalty if you need coverage later on.

Medicare Advantage Plans (Part C)

Medicare Advantage (MA) plans (also known as Medicare Part C plans) are offered by private health insurance companies to provide Medicare benefits as an alternative to Medicare Parts A and B, and usually D. Part C enrollees are still required to pay their premiums for Part B and Part A (if applicable) coverage, but will not need to purchase Medigap coverage because of the expanded coverage offered by Part C plans. The plan must provide all Part A and Part B services, and Part D coverage if prescription drug coverage is included in the plan. MA plans can provide this coverage in different ways, with varying costs and restrictions that can affect how and when you can get care. All MA plans must cover all services that Original Medicare covers.

Medicare Advantage plans do not allow the purchase of a Medigap policy and will not allow an existing Medigap policy to be used to pay for the out-of-pocket expenses associated with the Medicare Advantage plan. Generally, Medicare Advantage plans will offer a drug prescription coverage. However, if the Medicare Advantage Plan does not offer a drug prescription program or does not require drug purchases to be through the plan, then a separate Medicare Part D plan may be purchased.

Medicare Advantage plans often charge a premium in addition to the Medicare Part B premium. The plan may also charge a copayment whenever you receive a service. There might be some customized options that allow for lower copayments or lower total out-of-pocket expenses.

Understanding the various features, benefits, and costs provided by Original Medicare when compared with coverage provided by Medicare Advantage plans allows an individual or family to:

1. Customize the health insurance program that best suits their medical needs. Careful consideration should be given to an individual's future health insurance needs, not just the health insurance needs of today. Switching plans later on can be difficult, as Medigap plans are only offered on a guaranteed issue basis initially. Guaranteed issue means that the insurance company cannot charge you more because of your health. If you need to purchase a Medigap plan outside of the guaranteed issue period, it will likely be much more costly, or even impossible to do so. The Patient Protection and Affordable Care Act of 2010 denies private insurers the right to use pre-existing conditions to reject coverage, but this does not apply to Medigap plans.
2. Determine the most cost effective way to pay for their medical needs with an understanding of their annual or maximum out of pocket expenses.
3. Ensure that their preferred hospitals, doctors and pharmacies can be used.
4. Ensure that they are covered when traveling domestically or internationally.

Medicare Enrollment – Part A, Part B and Part D

Eligible individuals have a seven-month window to enroll in Medicare, which starts three months before the month of their 65th birthday and ends three months after. Those already receiving Social Security at age 65 or who have been receiving Social Security Disability Insurance (SSDI) for 24 months, will be automatically enrolled in Medicare Parts A and B. Three months before their 65th birthday or their 24th SSDI payment, the individual will receive their new Medicare card and a letter explaining that they have been automatically enrolled in both Medicare Part A and Part B. The Part B premium will be automatically deducted from their Social Security check beginning the month their coverage begins, but these new enrollees will have the option to decline Part B. Part A cannot be declined if an individual is receiving Social Security.

Individuals who are 65 but are not receiving Social Security retirement benefits will need to proactively enroll in Medicare. Moreover, those who do not enroll in Medicare within three months after the month of their 65th birthday may be subject to a late enrollment penalty.

Enrollment Periods for Medicare Part A and B

Those eligible for Medicare but not currently receiving Social Security retirement benefits have **three** different time periods during which they can enroll in Medicare Parts A and B.

1. ***Initial Enrollment Period (IEP)*** – Eligible individuals can enroll in Medicare at any time during a seven-month period including the three months before, the month of, and the three months following their 65th birthday. The actual date when Medicare coverage is effective depends on when enrollment occurred:

Enrollment Month	Coverage Start Date
3 months before birthday month	1st of the month of 65th birthday
2 months before birthday month	1st of the month of 65th birthday
1 month before birthday month	1st of the month of 65th birthday
Birthday month	One month after enrollment
One month after birthday month	Two months after enrollment
Two months after birthday month	Three months after enrollment
Three months after birthday month	Three months after enrollment

For example, someone who turns 65 in April, your IEP and coverage start date would be:

Enrollment Month	Coverage Start Date
January, February or March	April 1
April	May 1
May	July 1
June	September 1
July	October 1

2. ***Special Enrollment Period (SEP)*** – Enrollment in Part B can be delayed without penalty if the individual was covered by employer health insurance through their or their spouse's current job when they first become eligible for Medicare at age 65. Enrollment can occur without penalty at any time (1) while the individual has group health coverage or (2) during the 8-month period that begins the month after the employment ends or coverage ends, whichever comes first. COBRA or retiree plans are NOT considered employer health plans for the purposes of this rule.

3. ***General Enrollment Period (GEP)*** – Anyone who misses their initial or special enrollment period must wait until the next GEP, which runs from January 1 through March 31 every year, to enroll. Coverage for these enrollees will begin July 1 of the year they enroll. These enrollees may also pay a penalty in the form of a higher premium for every year they delay enrolling in Medicare Part B.

To avoid a gap in coverage, one can coordinate the start date of their Medicare coverage with the termination of their prior coverage.

Enrollment Periods for Medicare Part D

Those enrolled in Medicare Part A and/or Part B can enroll in Medicare Part D during the Part A and B Initial Enrollment Period (IEP). The effective date of the Part D coverage is based on the enrollment date. During the IEP, if you enroll during the:

Enrollment Date	Coverage Start Date
First three months of the IEP	Month when first eligible for Part A or B
Last four months of the IEP	Month following the month of enrollment

Choosing to not join a Medicare Private Drug Plan during the Initial Enrollment Period may delay coverage until the fall Open Enrollment, which runs from October 15 to December 7 of each year. Coverage selected during the Open Enrollment period begins on January 1 of the following year. In addition, there may also be a premium penalty for deferring the start of coverage.

Special Enrollment Periods are available under a variety of circumstances. As long as some has "creditable" coverage, meaning the prescription drug plan is at least as good as Medicare, they will not incur a late enrollment penalty when enrolling in Part D. The availability of these SEPs and the effective date for benefits varies based on the reason for the SEP.

The chart below identifies two common circumstances (many others exist) for a SEP, the enrollment time frame, and when benefits become available:

Part D - Special Enrollment Period		
Reason for SEP	**Enrollment Availability**	**Benefit Availability**
Through no fault of your own, lose creditable drug coverage ("creditable") or your drug coverage is reduced so that it is no longer creditable	Begins the month you are told your coverage will end Ends the later of: • 2 months after you lose coverage; **or** • 2 months after you receive notice	• The first day of the month after you submit a completed application; **or** • up to 2 months after your SEP ends, if you request it
You choose to: • enroll in an employer / union-sponsored Medicare drug plan • disenroll from a Medicare drug plan to take employer/union-sponsored drug coverage (including COBRA)	Begins the same period of time when your employer would normally allow you to make changes to your employee health care coverage. Ends 63 days after the month in which your employer or union coverage ends.	Up to three months after the month in which you submit a completed enrollment application.

Insurance Premiums, Deductibles and Co-Insurance Charges

Like any other insurance policy, enrollees in Medicare are responsible for monthly premiums, annual deductibles and coinsurance charges. These amounts are dependent on a variety of factors, including work history, income levels and enrollment date.

Part A – Hospital insurance

Part A monthly premiums are based on the individual's, or their spouse's, work history. If either of the two have at least 40 calendar quarters (10 years) of work in any job at which they paid Social Security taxes in the U.S., or either was a federal employee after December 31, 1982 or a state or local employee after March 31, 1986, they will be eligible for Medicare Part A at no cost.

If an individual did not work at least 40 quarters and isn't eligible for Social Security benefits, but their spouse did, the non-working spouse may be eligible for free Medicare Part A based on the working spouse's work history. This applies when the non-working spouse:

- Is currently married to a spouse who is eligible for Social Security benefits (either for Social Security retirement benefits starting at 62 or disability at any age) and married for at least one year before applying.
- Is divorced and the former spouse is eligible for Social Security benefits (either retirement or disability). In addition, they must have been married for at least 10 years and the non-working spouse must be single at the time of application for benefits.
- Is widowed and they were married for at least nine months before their spouse died. In addition, they must be single at the time of application for benefits.

If neither spouse qualifies for premium-free Part A, coverage can be purchased. The premium is based on the insured's work history.

Medicare Part A provides for 60 days of fully covered hospital stays, and an additional 30 days at a reduced cost to the insured, for a total of 90 days of coverage per benefit period. A benefit period begins when the patient is admitted to a hospital and ends after they have been out of the hospital or skilled nursing facility (SNF), or stop receiving Medicare-covered skilled services at the SNF, for at least 60 days in a row.

For hospital stays longer than 90 days, Part A offers 60 lifetime reserve days of coverage. These are flexible days that can be used at the insured's discretion, but can only be used once during their lifetime. These reserve days provide a lower level of coverage, but protect those with hospital stays longer than 90 days, and can be allocated over multiple hospital stays. Once the insured has exceeded 90 days in a hospital, the lifetime reserve days will automatically begin being used unless the insured notifies the hospital within 90 days of leaving the hospital, in writing, that they do not want to use their lifetime reserve days for that event.

When deciding whether to use their lifetime reserve days, the insured should compare the actual cost charged by the provider to the co-insurance amount for the reserve days. For example, if the hospital costs are just

slightly higher than the daily coinsurance charge, it may be appropriate to save a lifetime reserve day for a future hospital stay that may be more expensive. If the average daily hospital costs are less than the coinsurance daily charge then you will not use up a lifetime reserve day. After you use up your 60 lifetime reserve days, Medicare will no longer pay for any coverage until you start a new benefit period.

The following table summarizes the premium, deductible and co-insurance charges paid by the insured individual for Medicare Part A coverage for 2016. These amounts may be adjusted annually.

Insurance Premium		Benefit Period Deductible	Hospital Co- Insurance Charges		Skilled Nursing Care Co- Insurance Charges	
Work History of you or your spouse	**Monthly Premium**		**Benefit Period**	**Daily Charge**	**Benefit Period**	**Daily Charge**
< 30 quarters	$411 per person	$1,288 per person	1-60 days	$0 per person	0-20 days	$0 per person
30-39 quarters	$226 per person		61-90 days	$322 per person	21-100 days	$161 per person
≥ 40 quarters	$0 per person		91-150 days (60 lifetime reserve days*)	$644 per person*	101+ days	100% of cost
			151+ days	100% of cost		

*The insured may decide to forego using their lifetime reserve days during that benefit period, in which case they will be responsible for 100% of the cost.

Part B – Medical Insurance

Premiums for Medicare Part B coverage are based primarily on the insured's income for the year two years prior to the year the coverage applies (for example, the premium for coverage in 2016 is based on the insured's income in 2014). Insured single individuals with income below $85,000 (couples below $170,000) are charged the base premium amount. For purposes of this test, income is defined as Adjusted Gross Income plus tax-exempt interest income. As income increases beyond those levels, the monthly premium amount increases (see the table below). This premium can either be deducted directly from the insured's Social Security benefits, or can be billed to the insured directly if they are not receiving benefits. Those that do have their Part B premiums deducted from their Social Security checks qualify to be "held harmless" from Medicare premium increases under certain circumstances.

The Hold-Harmless Provision is a special rule for Medicare participants who have their premiums deducted from their Social Security benefits. The provision states that the increase in Medicare premiums due to annual cost of living adjustments (COLA) cannot exceed, in true dollar terms, the COLA increase for Social Security payments for the same year. In other words, Social Security recipients won't see a net reduction in their benefits due to increases in Medicare premiums. Approximately 70% of Social Security and Medicare recipients are eligible to be Held Harmless in any given year. Those who cannot be held harmless include:

- Those whose Medicare premiums are not withheld from their Social Security benefits,
- New Medicare enrollees (people not eligible to enroll in Medicare until after an annual premium increase occurs),
- Higher-income beneficiaries subject to the Income-Related Monthly Adjustment Amount (IRMAA) (Modified adjusted gross income greater (MAGI) than $85,000 for individuals and $170,000 for couples)

The following table summarizes the premium, deductible, and co-insurance charges paid by the insured individual for Medicare Part B coverage for 2016. Because there was no cost-of-living increase on Social Security benefits in 2016, there are two 2016 base premium amounts—one for those held harmless and one for those who are not held harmless. The below amounts are adjusted annually.

<table>
<tr><th colspan="4">Monthly Premium</th><th>Premium Penalty</th><th>Annual Deductible</th><th colspan="2">Medical Co- Insurance Charges</th></tr>
<tr><th colspan="2">Adjusted Gross Income + Tax Exempt Income</th><th rowspan="2">If Held Harmless</th><th rowspan="2">Not Held Harmless</th><td rowspan="6">• 10% for every year that you fail to enroll once you are eligible and do not have a SEP.
• 10% penalty is charged to the base premium amount and then added to the actual premium amount, if the income test premium rules apply.

• Example:
• Single Individual is eligible in 2014, but does not enroll until 2016 and had income of $150,000 in 2014.
• Penalty = $121.80 (2015 base) x .2 (10%/ year) = $24.36
• 2016 Premium = $24.36 (penalty) +$243.60 (income test premium) = $267.96
• The penalty amount will carryover every year.</td><td rowspan="6">$166 per person</td><th>Type of Care</th><th>Daily Charge</th></tr>
<tr><th>Single</th><th>Married Filing Joint</th><td>Medical Services</td><td>20%</td></tr>
<tr><td>< $85,000</td><td>< $170,000</td><td>$104.90</td><td>$121.80</td><td>Out Patient Hospital Care</td><td>Can‘t exceed Part A deductible</td></tr>
<tr><td>$85,001 - $107,000</td><td>$170,001 - $214,000</td><td>n/a</td><td>$170.50</td><td>Out Patient Mental Health</td><td>40%</td></tr>
<tr><td>$107,001 - $160,000</td><td>$214,001- $320,000</td><td>n/a</td><td>$243.60</td><td>Annual Wellness</td><td>$0</td></tr>
<tr><td>$160,001 - $214,000</td><td>$320,001 - $428,000</td><td>n/a</td><td>$316.70</td><td colspan="2" rowspan="2">Service Providers may or may not accept Medicare.

Service Providers that accept Medicare may not accept the Medicare pre-approved cost for service. Under these circumstances, the service provider may charge up to an additional 15% out-of-pocket fee to the insured.</td></tr>
<tr><td>> $214,000</td><td>> $428,000</td><td>n/a</td><td>$389.80</td></tr>
</table>

The income brackets used to calculate the income-related monthly adjustment amount will be changing for the 2018 premium year. The brackets will be condensed and the top bracket (tier 5) will start at $320,001, rather than $428,001. Any income tax planning that can be done to avoid these higher premiums should start in 2016.

Part D –Prescription Drug Plan

Because Medicare Part D coverage is purchased from companies contracted with the government, coverage levels – and therefore premiums – will vary based on the type of coverage purchased. The premium charged by the insurance company is subsidized by the government, but the excess amount is paid by the insured. Beginning in 2011, this government subsidy is reduced for individuals with income exceeding certain thresholds, using the same income ranges as are used for the Part B premium adjustments. This reduced subsidy results in a larger premium cost to individuals with higher levels of income.

The base beneficiary premium amount for 2016 is $34.10 per month for the lowest income bracket, but will vary depending on the coverage purchased. The Part D premium (which varies by plan) can be deducted from Social Security benefits or billed by the provider. Any IRMAA-related premium increase charged to those with higher income levels must be deducted from Social Security benefits.

In addition to the premium cost, there is also a deductible and co-insurance charges. These costs are subject to change every year. In addition, the insurer can change the coverage applied to drugs purchased at any time. Lastly, the out-of-pocket costs will depend on the coverage period at the time the drugs are purchased.

There are four different coverage periods for Medicare prescription drug coverage.

1. ***Deductible period*** – If the plan has a deductible, the insured will have to pay the full cost of drugs (100 percent) until that amount is met. While deductibles can vary from plan to plan, no plan's deductible can be higher than $360 (for 2016).
2. ***Initial coverage period*** – This period begins after the deductible, if any, is met. During this period the insured pays a portion of the cost of drugs (coinsurance or copayment), which varies by drug and by plan, with the plan will pay the rest. The length of this initial coverage period depends on the insured's out of pocket drug costs and the plan's benefit structure. Most plans' initial coverage period ends after accumulating $3,310 in total drug costs (for 2016).
3. ***Coverage Gap ("Doughnut Hole") period*** – After the total drug costs (the total amount paid by the insured and by the plan) reach a certain amount ($3,310 for 2016), there is a coverage gap. During this period, the insured will still pay the drug plan's monthly premium but the plan does not pay for your drugs. However, as a result of the Affordable Care Act, there are discounts that will help pay for drugs during this time. Since 2011, the coverage gap has been in the process of being phased out. In 2016, there will be a 55% manufacturers discount on most brand name drugs and a 58% discount for generic drugs. The coverage gap will be completely phased out in 2020 when those with coverage will pay no more than 25 percent of the cost of their drugs at any point during the year.
4. ***Catastrophic Coverage period*** – In all Medicare private drug plans, after the insured has paid $4,850 (for 2016) in out-of-pocket costs for covered drugs (regardless of the total drug costs), catastrophic coverage is reached.

- Costs that count toward this threshold include:
  - Deductible
  - Initial coverage period costs
  - Coverage gap costs – what you pay plus the discount on brand-name drugs
  - Amounts paid by others, including family members, most charities or other persons on your behalf
  - State Pharmaceutical Assistance Programs, AIDs drug assistance programs, and the Indian Health Service.
- Costs that do NOT count towards this threshold include:
  - The drug plan premium
  - The discount on generic drugs
  - The pharmacy dispensing fee
  - What you pay for drugs not covered by the plan

At the catastrophic coverage level, the insured will pay either a 5 percent coinsurance on the cost of covered drugs or a co-pay of $2.95 for covered generic drugs and $7.40 for covered brand-name drugs, whichever is greater. The insurer should keep track of how much money the insured spends out-of-pocket on covered prescription drugs and how close they are to the coverage gap. This information should be printed on monthly statements, but should be verified for accuracy.

Many drug plans include both "preferred" and "non-preferred" pharmacies in their pharmacy networks and prices may be lower for your drugs at preferred pharmacies than at non-preferred pharmacies.

Each Medicare Part D plan will also have its own drug formulary (list of covered drugs). Many Medicare drug plans place drugs into different tiers on their formularies. Drugs in each tier have a different cost. A drug in a lower tier will generally cost you less than a drug in a higher tier. Some plans will place the same drug at in a different tier. It is important to evaluate what a plan will cover compared to what drugs you are actually taking.

The below table summarizes the Medicare Part D plan costs:

Monthly Premium			Premium Penalty	Annual Deductible	Drug Co- Insurance Charges	

Adjusted Gross Income + Tax Exempt Income		**Base Beneficiary Premium (Actual Premium varies by Plan)**	• 1% for every month that you fail to enroll once you are eligible and do not have a SEP.
			• 1% penalty is charged to the base premium amount and then added to the actual premium amount, if the income test premium rules apply.
			• Example:
			  • Single Individual is eligible in April 2014, but does not enroll until January 2016 and had income of $150,000 in 2014.
			  • Penalty = $34.10 (2016 base) x .21 (1%/month) = $7.16
			  • 2015 Monthly Premium = $7.16 (penalty) + $34.10 (2016 base) + $32.80 (income test premium) = $74.06
			• The penalty amount will carryover every year
				Varies by Plan but can't exceed $360	**Period**	**Cost**

Single	**Married Filing Joint**					
< $85,000	< $170,000	Your plan premium			Deductible ($0-$360)	100%
$85,001 - $107,000	$170,001 - $214,000	$12.70 + your plan premium			Initial Coverage ($361 - $3,310)	25% (national plan average)
$107,001 - $160,000	$214,001- $320,000	$**Source: The Kaiser Family Foundation's *Medicare Part D: A First Look at Plan Offerings in 2016 (Appendix)*** 32.80 + your plan premium			Coverage Gap ($3,311 - $4,850)	45% Brand 58% Generic
$160,001 - $214,000	$320,001 - $428,000	$52.80 + your plan premium			> $4,850	Greater of: 5% or $7.40 for Brand and $2.95 for Generic
> $214,000	> $428,000	$72.90 + your plan premium			The Patient Protection and Affordable Care Act phases out the Coverage Gap Period by 2020. Prior to 2011, you paid 100% of your drugs during the Coverage Gap Period. Starting in 2020, you will not pay more than 25% for your drugs at any time during the year.	

Medicare Supplement Insurance Plans

Medicare Supplement Policies, often referred to as "Medigap" plans, are additional policies that may be purchased after a person has signed up for Parts A and B (original Medicare) and pays the Part B premium. These policies may cover deductibles, co-insurance, copayments and other out-of-pocket expenses that original Medicare does not cover, along with effectively creating an out-of-pocket maximum on covered healthcare expenses. The extent to which these uncovered expenses are covered by a Medigap plan will depend on the coverage that is chosen. Medigap plans are issued by private insurance companies. The plans are standardized, but premiums vary widely from region to region and insurance company to insurance company.

Every Medicare Supplement Policy must follow federal and state laws designed to protect consumers. Therefore, insurance companies can only sell "standardized" Medigap policies. Most states identify these plans with letters A through N. In Massachusetts, Minnesota, and Wisconsin, plans are structured differently and are not referred to by their letter designations. Below is a table of the standardized "letter" plans available:

	A	B	C	D	F / F*	G	K	L	M	N
Hospital Part A Coinsurance + 365 lifetime reserve days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%, but requires copayment: $20 office visits $50 ER
Hospice Part A Coinsurance	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Medical Part B Coinsurance	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
3 Pints of Blood	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A Deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B Deductible			100%		100%					
Part B Excess					100%	100%				
Skilled Nursing Facility Coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Home Healthcare Coinsurance	100%	100%	100%	100%	100%	100%	50%	75%	50%	100%
Foreign Travel Emergency			80% $250 deductible $50,000 lifetime benefit	80% $250 deductible $50,000 lifetime benefit	80% $250 deductible $50,000 lifetime benefit	80% $250 deductible $50,000 lifetime benefit			80% $250 deductible $50,000 lifetime benefit	80% $250 deductible $50,000 lifetime benefit
Out of Pocket Limit							$4,960 100% there after	$2,480 100% there after		
					Offers Plan F* with a high deductible of $2,000 and a separate deductible for Foreign Travel Emergency					

All States must offer Plan A. However, some plans may not be available in all states. Plans E, H, I and J are no longer available for sale, but existing policies will still provide coverage.