Bill Vreeland

Senior Health Insurance Group

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Licensed since 1987… 29 years!

My Motivations…

Easy to Reach

- Office Phone: 678-701-5513
- Toll Free: 888-611-4073
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- Email:bill@seniorhealthinsurancegroup.com

I answer the phone!

What is Medicare?

Medicare is health insurance for the following:

- People 65 or older
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

The Different Parts of Medicare

The different parts of Medicare help cover specific services:

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home health care

Medicare Part B (Medical Insurance)

- Helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment, and home health care
- Helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse

Medicare Part C (also known as Medicare Advantage)

Offers health plan options run by Medicare-approved private insurance companies. Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B. Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D). Some Medicare Advantage Plans may include extra benefits for an extra cost.

Medicare Part D (Medicare Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs
- Run by Medicare-approved private insurance companies

2016 Medicare Costs

Medicare Part A (Hospital Insurance) Costs

Part A Monthly Premium

Most people don't pay a Part A premium because they paid Medicare taxes while working. If you don't get premium-free Part A, you pay up to $411 each month.

Hospital Stay

In 2016, you pay

- $1,288 deductible per benefit period
- $0 for the first 60 days of each benefit period
- $322 per day for days 61–90 of each benefit period
- $644 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime)

Skilled Nursing Facility Stay

In 2016, you pay

- $0 for the first 20 days of each benefit period
- $161.00 per day for days 21–100 of each benefit period
- All costs for each day after day 100 of the benefit period

Medicare Part B (Medical Insurance) Costs

Part B Monthly Premium

You pay a Part B premium each month. Most people who get Social Security benefits will continue to pay the same Part B premium amount as they paid in 2015. This is because there wasn't a cost-of-living increase for 2016 Social Security benefits. You'll pay a different premium amount in 2016 if:

- You enroll in Part B for the first time in 2016.
- You don't get Social Security benefits.
- You're directly billed for your Part B premiums.
- You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $121.80.)
- Your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount.

If you're in 1 of these 5 groups, here's what you'll pay:

If your yearly income in 2014 was			You pay (in 2016)
File individual tax return	**File joint tax return**	**File married & separate tax return**	
$85,000 or less	$170,000 or less	$85,000 or less	$121.80
above $85,000 up to $107,000	above $170,000 up to $214,000	N/A	$170.50
above $107,000 up to $160,000	above $214,000 up to $320,000	N/A	$243.60
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 up to $129,000	$316.70
above $214,000	above $428,000	above $129,000	$389.80

If you have questions about your Part B premium, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you pay a late enrollment penalty, these amounts may be higher.

Part B Deductible—$166 per year

Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D) Premiums

Visit Medicare.gov/find-a-plan to get plan premiums. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also call the plan or your State Health Insurance Assistance Program.

Part D Monthly Premium

The chart below shows your estimated prescription drug plan monthly premium based on your income. If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium.

If your yearly income in 2014 was			You pay (in 2016)
File individual tax return	**File joint tax return**	**File married & separate tax return**	
$85,000 or less	$170,000 or less	$85,000 or less	Your plan premium
above $85,000 up to $107,000	above $170,000 up to $214,000	N/A	$12.70 + your plan premium
above $107,000 up to $160,000	above $214,000 up to $320,000	N/A	$32.80 + your plan premium
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 up to $129,000	$52.80 + your plan premium
above $214,000	above $428,000	above $129,000	$72.90 + your plan premium

2016 Part D National Base Beneficiary Premium — $34.10

This figure is used to estimate the Part D late enrollment penalty and the income-related monthly adjustment amounts listed in the table above. The national base beneficiary premium amount can change each year. See your Medicare & You handbook or visit Medicare.gov for more information.

For more information about Medicare costs, visit Medicare.gov.

2016 MEDICARE PART A

Part A is Hospital Insurance and covers costs associated with confinement in a hospital or skilled nursing facility.

WHEN YOU ARE HOSPITALIZED FOR:	MEDICARE COVERS	YOU PAY
1-60 DAYS	Most confinement costs after the required Medicare deductible	**$1,288** DEDUCTIBLE
61-90 DAYS	All eligible expenses after patient pays a per-day copayment	**$322** A DAY COPAYMENT as much as: **$9,660**
91-150 DAYS	All eligible expenses after patient pays a per-day copayment (These are Lifetime Reserve Days that may never be used again)	**$644** A DAY COPAYMENT as much as: **$38,640**
151 DAYS OR MORE	NOTHING	**YOU PAY ALL COSTS**
SKILLED NURSING CONFINEMENT: Following an inpatient hospital stay of at least 3 days and enter a Medicare-approved skilled nursing facility within 30 days after hospital discharge and receive skilled nursing care	All eligible expenses for the first 20 days; then all eligible expenses for days 21-100 after patient pays a per-day copayment	After 20 days **$161** A DAY COPAYMENT as much as: **$12,880**

2016 MEDICARE PART B

Part B is Medical Insurance and covers physician services, outpatient care, tests, and supplies.

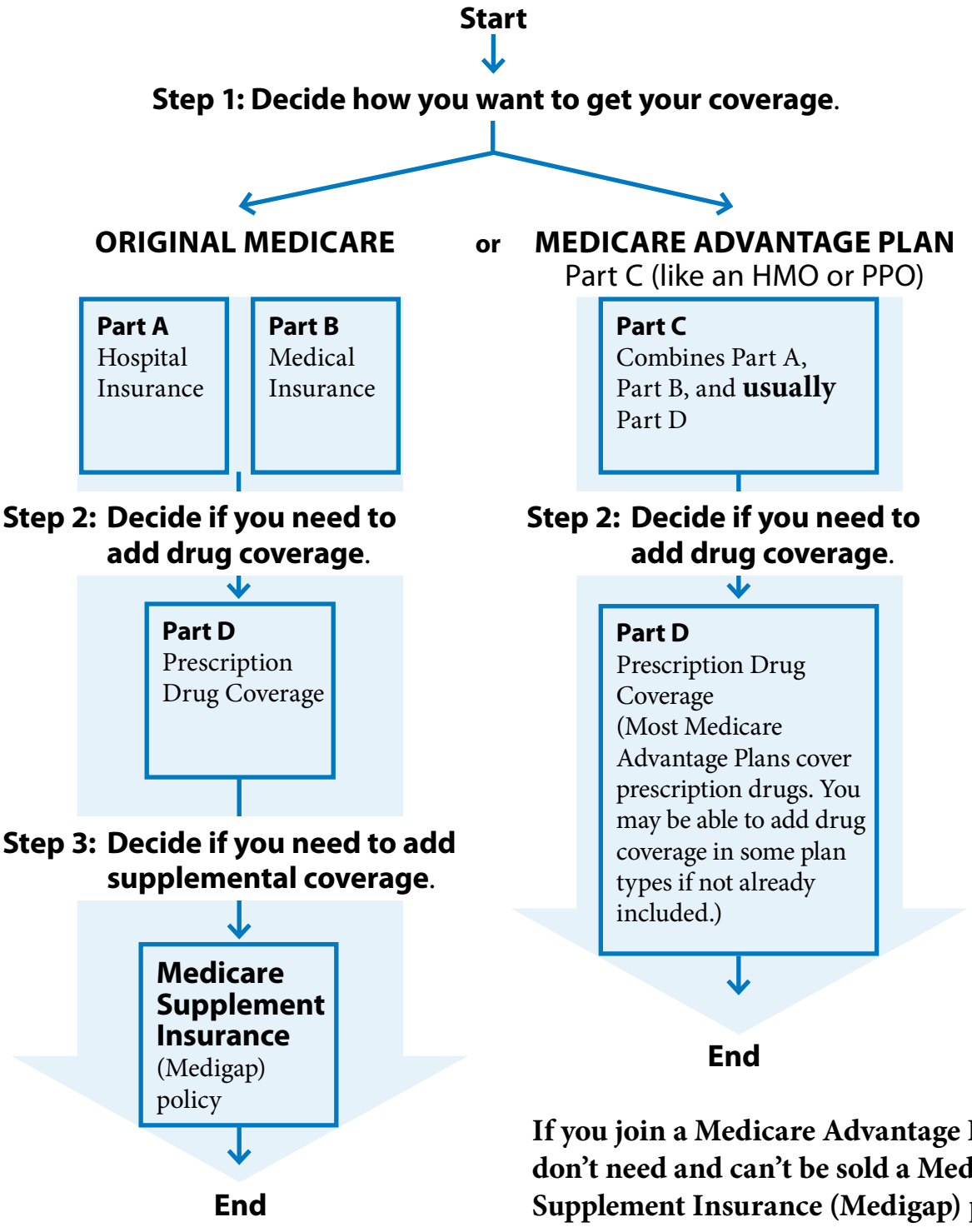
ON EXPENSES INCURRED FOR:	MEDICARE COVERS	YOU PAY
ANNUAL DEDUCTIBLE	Incurred Expenses after the required Medicare deductible	$166 Annual Deductible
MEDICAL EXPENSES Physicians' services for inpatient and outpatient medical/surgical services; physical/speech therapy; and diagnostic tests	80% of approved amount	20% of approved amount*
CLINICAL LABORATORY SERVICES Blood tests; urinalysis	Generally100% of approved amount	Nothing for services
HOME HEALTHCARE Part-time or intermittent skilled care; home health aide services; durable medical supplies; and other services	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount* for durable medical equipment
OUTPATIENT HOSPITAL TREATMENT Hospital services for the diagnosis or treatment of an illness or injury	Medicare payment to hospital, based on outpatient procedure payment rates	Coinsurance based on outpatient payment rates
BLOOD	80% of approved amount after first 3 pints of blood.	First 3 pints plus 20% of approved amount* for additional pints
EXCESS DOCTOR CHARGES (Above Medicare-approved amount)	0% above approved amount	All costs

*On all Medicare-covered expenses, a doctor or other healthcare provider may agree to accept Medicare assignment. This means the patient will not be required to pay any expense in excess of Medicare's approved charge. The patient pays only 20% of the approved charge not paid by Medicare.

Physicians who do not accept assignment of a Medicare claim are limited as to the amount they can charge for covered services. In 2015, the most a physician can charge for services covered by Medicare is 115% of the approved amount for nonparticipating physicians. *Note: In New York, the most a physician can charge for services covered by Medicare is 105% of the approved amount for nonparticipating physicians. For routine office visits covered by Medicare, a nonparticipating physician can charge up to 115% of the fee schedule amount.*

Your Medicare Coverage Choices at a Glance

There are two main ways to get your Medicare coverage: Original Medicare or a Medicare Advantage Plan. Use these steps to help you decide which way to get your coverage.



If you join a Medicare Advantage Plan, you don't need and can't be sold a Medicare Supplement Insurance (Medigap) policy.

Two Types

Policy

No Change

No Risk

You Choose	They Choose
Aetna	Humana
Equitable	Healthspring
Manhattan Life	Coventry
New Era	AARP
Mutual Of Omaha	Universal Health
AARP	Kaiser Permanente

Contract

Change

Risk

Medigap policies are standardized

Every Medigap policy must follow federal and state laws designed to protect you, and it must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only a "standardized" policy identified in most states by letters A through D, F through G, and K through N. All policies offer the same basic benefits, but some offer additional benefits so you can choose which one meets your needs. In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

Note: Plans E, H, I, and J are no longer available to buy, but if you already have one of those policies, you can keep it. Contact your insurance company for more information.

How do I compare Medigap policies?

Different insurance companies may charge different premiums for the same exact policy. As you shop for a policy, be sure you're comparing the same policy (for example, compare Plan A from one company with Plan A from another company).

In some states, you may be able to buy a type of Medigap policy called Medicare SELECT (a policy that requires you to use specific hospitals and, in some cases, specific doctors or other health care providers to get full coverage). If you buy a Medicare SELECT policy, you have the right to change your mind within 12 months and switch to a standard Medigap policy.

Definitions of blue words are on pages 145–148.

The chart below shows basic information about the different benefits that Medigap policies cover. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest.

Note: You'll need more details than this chart provides to compare and choose a policy. See page 96 to find out where to get more information.

	Medicare Supplement Insurance (Medigap) plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Medicare Part B coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%** **
Blood (first 3 pints)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Part A hospice care coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Skilled nursing facility care coinsurance			**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 charges					**100%**	**100%**				
Foreign travel emergency (up to plan limits)			**80%**	**80%**	**80%**	**80%**			**80%**	**80%**
							Out-of-pocket limit in 2015			
							$4,940	$2,470		

* Plan F also offers a high-deductible plan in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,180 in 2015 before your policy pays anything.

** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

EQUITABLE LIFE & CASUALTY INSURANCE COMPANY

Outline Of Medicare Supplement Plans Sold for Effective Date on or After June 1, 2010

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan A. Some plans may not be available in your state.

Basic Benefits:

Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end;

Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of the part B coinsurance or copayments;

Blood - First three pints of blood each year;

Hospice - Part A coinsurance.

A❖	B	C	D	F❖ F*	G❖	K	L	M	N❖
Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visits and up to $50 co-payment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-Pocket limit $4960; paid at 100% after limit reached	Out-of-Pocket limit $2480; paid at 100% after limit reached		

❖Plans currently available for sale.

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,288	$0	$1,288 (Part A Deductible)
61st thru 90th day	All but $322 per day	$322 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $644 per day	$644 per day	$0
– once lifetime reserve days are used, additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
– beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 per day	$0	Up to $161 per day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once You have been billed $166 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $166 of Medicare-approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $166 of Medicare-approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0
61st thru 90th day	All but $322 per day	$322 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $644 per day	$644 per day	$0
– once lifetime reserve days are used, additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
– beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 per day	Up to $161 per day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once You have been billed $166 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $166 of Medicare-approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $166 of Medicare-approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONT'D.)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0
61st thru 90th day	All but $322 per day	$322 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $644 per day	$644 per day	$0
– once lifetime reserve days are used, additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
– beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 per day	Up to $161 per day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once You have been billed $166 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $166 of Medicare-approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $166 of Medicare-approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONT'D.)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0
61st thru 90th day	All but $322 per day	$322 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $644 per day	$644 per day	$0
– once lifetime reserve days are used, additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
– beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 per day	Up to $161 per day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once You have been billed $166 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $166 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 Generally 80%	$0 Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the Insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	$166 (Part B Deductible) Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the Insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $166 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 $166 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	$0	$0

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONT'D.)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $166 of Medicare-approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

2016 Part D-Prescription Drug Coverage

Deductible Phase: 0-$360

Initial Coverage Phase: $3,310 (Total Retail Cost of Medication)

Coverage Gap: Your $ - $4,850

58% Amount you pay for Generics

45% Amount you pay for Brand

Catastrophic Coverage: You pay only a small coinsurance amount or copayment for covered drugs for the rest of the year.

2016 LIS Benefits and Qualifications

Low Income Subsidy (LIS) is a Federal program designed to assist Medicare recipients with limited **income** and **resources** with the cost of their prescription drugs.

LIS beneficiaries can receive assistance with their Part D **premiums**, **deductibles**, **copays** and **coverage gap** with all Part D and MAPD plans available nationwide. Plus LIS members have a **continuous** enrollment period!

Low Income Subsidy Enrollment

Some Medicare beneficiaries automatically qualify for LIS benefits; they include Full Benefit Dual Eligible, Medicare Savings Program recipients (QMB, SLMB, QI, etc.), and those receiving SSI payments.

Of the millions of Medicare beneficiaries, 34% live at or below 150% of the Federal Poverty Level. For those who don't automatically qualify, they can enroll through the Social Security Administration in one of three ways.

Option 1 - Apply at local Social Security office

Option 2 - Apply by calling 1-800-772-1213

Option 3 - Enroll online by visiting http://www.ssa.gov/prescriptionhelp

2016 Income and Resource Limits 150% of Federal Poverty Level

	Individual	Married
Income*	$17,655	$23,895
Resources	$12,140	$24,250

*Adjusted Gross Income, annual. AK & HI differ

The following are **NOT** included in income:

- Housing assistance,
- Medical treatment and drugs,
- Food stamp assistance, etc.

The following items are included in resources:

- Bank accounts,
- Stocks and bonds,
- Real estate (other than your primary residence), etc.

The following are **NOT** included in resources:

- The house you live in,
- Your car,
- Other personal possessions, etc.

Co-pay Levels

Copayments for covered medications can vary:

Generic/Preferred Multi-Source Drugs
$1.20, $2.65 or 15%

Other Drugs
$3.60, $6.60 or 15%

Late Enrollment Penalty

If the beneficiary has a Late Enrollment Penalty for Part D, LIS will eliminate the monthly cost.

Deductible Coverage

Deductible for incomes <135% of FPL is $0
Deductible for incomes 135-150% of FPL is $66

Coverage Gap or Donut Hole

LIS eliminates the Coverage Gap for beneficiaries. Regular cost-sharing will continue.

Copayments above Out-of-Pocket Threshold

Less than 135% of FPL: $0
Between 135-150% of FPL: $2.65 or $6.60

Revised July 2013

4 Ways to Help Lower Your Medicare Prescription Drug Costs

Are you a person with Medicare who's having trouble paying for prescription drugs? Joining a Medicare Prescription Drug Plan may help, even if you have to pay a late enrollment penalty.

There are other ways you may be able to save. Consider switching to drugs that cost less. Ask your doctor if there are generic, over-the-counter, or less-expensive brand-name drugs that could work just as well as the ones you're taking now. Switching to lower-cost drugs can save you hundreds or possibly thousands of dollars a year. Visit the Medicare Plan Finder at Medicare.gov/find-a-plan to get information on ways to save money in your Medicare drug plan. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You can also help lower your Medicare prescription drug costs by:

1. **Exploring national and community-based programs** that might offer assistance (like the National Patient Advocate Foundation or the National Organization for Rare Disorders) that may have programs that can help with your drug costs. Get information on federal, state, and private assistance programs in your area on the Benefits Check Up website, benefitscheckup.org. The help you get from some of these programs may count toward your true out-of-pocket (TrOOP) costs. TrOOP costs are the expenses that count toward your Medicare drug plan out-of-pocket expenses—up to $4,750 for 2013. These costs determine when your catastrophic coverage will begin.
2. **Looking at State Pharmaceutical Assistance Programs (SPAP)** to see if you qualify. SPAPs in 22 states and 1 territory offer some type of coverage to help people with Medicare with paying drug plan premiums and/or cost sharing. Find out if your state has a State Pharmaceutical Assistance Program at Medicare.gov/pharmaceutical-assistance-program/state-programs.aspx or calling 1-800-MEDICARE. SPAP contributions may count toward your TrOOP costs.

3. **Looking into Manufacturer's Pharmaceutical Assistance Programs (sometimes called Patient Assistance Programs (PAPs))** offered by the manufacturers of the drugs you take. Many of the major drug manufacturers offer assistance programs for people enrolled in a Medicare drug plan. Find out whether the manufacturers of the drugs you take offer a Pharmaceutical Assistance Program by visiting Medicare.gov/pap/index.asp or calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Assistance from PAPs isn't part of Medicare Part D, so any help you get from this type of program won't count toward your TrOOP costs.

4. **Applying for Extra Help paying for your Medicare prescription drugs**. If you have Medicare and have limited income and resources, you may qualify for Extra Help paying for your prescription drugs. To apply for Extra Help, contact Social Security at socialsecurity.gov or by calling 1-800-772-1213. TTY users should call 1-800-325-0778.

If you need help finding resources, like the ones described above, call your State Health Insurance Assistance Program (SHIP) for free personalized counseling to people with Medicare. Get their phone number by visiting Medicare.gov/contacts, or calling 1-800-MEDICARE.

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A Hypothetical Example

PART A of this hypothetical situation involves a patient who was confined in a hospital for 170 days. (These days need not be consecutive; as long as the patient was never out of the hospital 60 days in a row, Medicare treats this as a single, long confinement.)

After the 60th day, the patient paid daily copayments of $315 for days 61-90, then $630 for days 91-150. He also paid extra charges for blood. Note, too, that Medicare Part A coverage completely ended after the 150th day in the hospital.

Next, our hypothetical patient entered a skilled nursing facility (SNF) for 100 days. Medicare paid for the first 20 days of confinement; for days 21 through 100, the patient paid $157.50 a day.

PART B eligible expenses for medical services included 10 visits to the doctor (each visit cost at least $100) plus specialists' fees and outpatient hospital services; the surgeon's and assistant surgeon's fees; the anesthesiologist's fee; 40 doctor visits while in the hospital and another 10 doctor visits while in the skilled nursing facility.

For each of these expenses (except outpatient hospital charges), Medicare recognized only its 'Approved Charge,' and then paid only 80% of that 'Approved Charge.' Our patient was responsible for the other 20%, as well as Part B Excess Expense. Additionally, he paid the $147 Medicare Part B deductible which is subtracted from the total "Approved Charges." For outpatient hospital charges, our patient's coinsurance liability was established by Medicare's national coinsurance rate for the type of service provided. Medicare's allowable total reimbursement to the hospital was less than the billed amount. Medicare pays the allowed reimbursement less the patient's coinsurance.

After Medicare Parts A and B — but without any supplemental insurance — our patient owed $93,952 for this illness. This example, coupled with this side-by-side guide, demonstrates how United American Medicare Supplement ProCare policies can make a dramatic difference for our patient's life savings.

PATIENT LIABILITY		PLAN A	PLAN B	PLAN C	PLAN D
PART A					
DAILY HOSPITAL CHARGES:					
Days 1-60, Part A Deductible	$1,260	Not Covered	$1,260	$1,260	$1,260
Days 61-90 @ $315 per day	$9,450	$9,450	$9,450	$9,450	$9,450
Days 91-150 @ $630 per day	$37,800	$37,800	$37,800	$37,800	$37,800
Days 151-170, All Charges	$20,000	$20,000	$20,000	$20,000	$20,000
BLOOD:					
3 Pints @ $60 per pint	$180	$180	$180	$180	$180
Part A Subtotal	**$68,690**	**$67,430**	**$68,690**	**$68,690**	**$68,690**
SKILLED NURSING FACILITY:					
Days 21-100 @ $157.50 per day	$12,600	Not Covered	Not Covered	$12,600	$12,600
Part A Total	**$81,290**	**$67,430**	**$68,690**	**$81,290**	**$81,290**
PART B					
OUTPATIENT HOSPITAL SERVICES: ▲					
50% of Medicare Allowed Charges	$381	$381	$381	$381	$381
PART B DEDUCTIBLE:					
	$147	NOT COVERED	NOT COVERED	$147	NOT COVERED
20% OF APPROVED CHARGES:					
(NOT COVERED BY MEDICARE)	$7,889	$7,889	$7,889	$7,889	$7,889
EXCESS CHARGES:					
(NOT COVERED BY MEDICARE)	$4,245	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Part B Total	**$12,662**	**$8,270**	**$8,270**	**$8,417**	**$8,270**
DEDUCTIBLE / OUT-OF-POCKET LIMIT					
MEDICARE UNPAID	***$93,952***	***$93,952***	***$93,952***	***$93,952***	***$93,952***
PLAN PAYS		***$75,700***	***$76,960***	***$89,707***	***$89,560***
PATIENT PAYS	***$93,952***	***$18,252***	***$16,992***	***$4,245***	***$4,392***

▲ The coinsurance owed for outpatient hospital services is established by Medicare based on the type of services provided.

	PLAN F	PLAN HDF	PLAN G	PLAN K	PLAN L	PLAN N
PART A						
DAILY HOSPITAL CHARGES:						
	$1,260	$1,260	$1,260	$630	$945	$1,260
	$9,450	$9,450	$9,450	$9,450	$9,450	$9,450
	$37,800	$37,800	$37,800	$37,800	$37,800	$37,800
	$20,000	$20,000	$20,000	$20,000	$20,000	$20,000
BLOOD:						
	$180	$180	$180	$90	$135	$180
Part A Subtotal	**$68,690**	**$68,690**	**$68,690**	**$67,970**	**$68,330**	**$68,690**
SKILLED NURSING FACILITY:						
	$12,600	$12,600	$12,600	$6,300	$9,450	$12,600
Part A Total	**$81,290**	**$81,290**	**$81,290**	**$74,270**	**$77,780**	**$81,290**
PART B						
OUTPATIENT HOSPITAL SERVICES: ▲						
	$381	$381	$381	(50%) $191	(75%) $286	$381
PART B DEDUCTIBLE:						
	$147	$147	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
20% OF APPROVED CHARGES:						
	$7,889	$7,889	$7,889	(50%) $3,945	(75%) $5,917	$7,689
EXCESS CHARGES:						
	$4,245	$4,245	$4,245	NOT COVERED	NOT COVERED	NOT COVERED
Part B Total	**$12,662**	**$12,662**	**$12,515**	**$4,135**	**$6,203**	**$8,070**
DEDUCTIBLE / OUT-OF-POCKET LIMIT		***DEDUCTIBLE $2,180***		***ANN LIMIT $4,940***	***ANN LIMIT $2,470***	
MEDICARE UNPAID	***$93,952***	***$93,952***	***$93,952***	***$93,952***	***$93,952***	***$93,952***
PLAN PAYS	***$93,952***	***$91,772***	***$93,805***	***$84,620***	***$87,090***	***$89,360***
PATIENT PAYS	***0***	***$2,180***	***$147***	***$9,332***	***$6,862***	***$4,592***

▲ The coinsurance owed for outpatient hospital services is established by Medicare based on the type of services provided.