Medicare and Medicaid: What You Need to Know

This program is sponsored by the Nevada Aging and Disability Services Division and is presented by the Access to Healthcare Network and Nevada Geriatric Education Center

Be sure to access the Aging and Disability Resource Center website at www.nevadaadrc.com/ when you have an opportunity.

It is a great resource for providers and community members.
Medicare and Medicaid: What You Need to Know

Presented by Access to Healthcare Network through a partnership with the Nevada Geriatric Education Center
Sponsored by Nevada Aging and Disability Services Division

Objectives:

At the end of this program you will understand:

• Who qualifies for Medicare
• The various parts of Medicare and what healthcare services they cover
• Which programs can assist low-income Medicare beneficiaries
• How Medicare and Medicaid programs overlap
• Who qualifies for Medicaid
• Resources for assistance in completing Medicaid applications.
Agenda

I. Medicare Overview
II. Break
III. Medicaid Overview
IV. Questions

Access to Healthcare Network (AHN)

- Access to Healthcare Network (AHN) - 501(c)3
  - Affordable health care for “working poor” Nevadans. Discounts include primary and specialty care, dental, vision and hospitals.

  Programs of AHN
  - Nevada Covering Kids and Families (CKF)
  - State Health Insurance Assistance Program (S.H.I.P)
  - State of Nevada Ryan White/ADAP
  - Women’s Health Connection
  - Colorectal Cancer Screening Program
What is Medicare?

Medicare is the federal health insurance program for:

• People 65 or older
• People under 65 with certain disabilities
• People of any age with End Stage Renal Disease (ERSD) which is permanent kidney failure requiring dialysis or a kidney transplant.

Application for benefits can be done by phone, on-line or in person at your closest Social Security office.

Part A: Hospital Coverage

Costs

• Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare-covered employment.
• The Part A premium is $248.00 per month for people having 30-39 quarters of Medicare-covered employment.
• The Part A premium is $451.00 per month for people who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters of Medicare-covered employment.

Hospitalization costs for 2012:

• $1,156 deductible per benefit period*
• $0 for the first 60 days of each benefit period*
• $289 per day for days 61–90 of each benefit period*
• $578 per “lifetime reserve day” after day 90 of each benefit period*(up to a maximum of 60 days over your lifetime)

* A benefit period begins at admission and ends 60 days from the date of discharge.
Part A: Hospital Coverage

Benefits
- Part A coverage pays 80% of hospital charges and beneficiary pays 20%.
- Helps cover “admitted” inpatient care in hospitals.
- Helps cover the costs of skilled nursing facility, hospice and home health care.
- Copayments, coinsurance and deductibles may apply for each service.
- Benefit periods apply.

Part B: Provider Coverage

Costs
- Monthly premium for Part B for 2012 is $99.90 and is usually deducted from a beneficiary’s Social Security check.
- 2012 Part B deductible $140.00 and co-payments usually are 20% of billed services.

Benefits
- Doctor’s visits and doctor ordered testing.
- Outpatient care (i.e. physical therapy).
- Home health services and durable medical equipment.
- Beginning Jan 1, 2012 there is no cost for yearly “Wellness” visit.
Part C: Medicare Advantage Plans

**Costs**
- Monthly premium deducted from the recipient's Social Security check.
- Costs vary from plan to plan.
- Co-payments may be less than the coinsurance and deductibles under Original Medicare.

**Benefits**
- Plans cover everything Original Medicare (Part A & B) covers.
- May offer additional benefits (i.e. prescription, dental and vision).
- Plans are administered by private insurance companies contracted with Medicare.
- Must have Part A and Part B to join one of these plans.
- Plans are star – rated to evaluate members’ feedback.
- Beginning January 2012, Medicare Beneficiaries can switch once to a Medicare Advantage Plan with a 5 star rating at anytime during the year.

Medicare Advantage Plans

**Pros**
- Advantage Plans are a “one-stop-shop” for medical care.
- Offers same rights and protections as Original Medicare.
- Can join even with a pre-existing condition, except for End Stage Renal Disease.
- Plans cannot charge more than Original Medicaid for certain services like chemotherapy, dialysis, and skilled nursing facility care.
- Plans have an annual cap for out of pocket expenses for Part A and Part B services. Amount can be different between plans, consider this when choosing a plan.
- Allows joining clinical research studies which can lower some costs.
- Co payments may be less than original Medicare.
Medicare Advantage Plans

**CONS**

- Limited availability in rural areas.
- Providers must accept Medicare Advantage Plans.
- Some advantage plans require a referral from a primary doctor to see a specialist.
- Costs will be higher for out-of-network providers.
- Cannot change plans until the next Annual Open Enrollment Period unless switching to a 5 star-rated plan or under special circumstances.
- Plan may not be accepted out of service region, consider this if traveling.

Part D – Prescription Drug Plans

Part D introduced in 2006 to help reduce the cost of prescription drugs for Medicare beneficiaries.

To be eligible for Part D benefits you must:
- Have Medicare Part A
- Join a part D plan contracted with Medicare.
- Already have Part A and Part B to join a Medicare Advantage Plan with Prescription Drug Coverage.

Other considerations:
- Even if not taking a lot of medications, consider joining a plan to avoid penalties (one percent per month from date of eligibility).
Part D continued

- Must have “creditable” drug coverage to avoid penalties. (Creditable: as good or better than what Medicare offers.)
- Call employer benefits administrator before signing up for any other coverage if other drug coverage is through an employer or union.
- Can switch drug plans during Annual Open Enrollment which occurs every fall.
- Changes can be made at anytime if approved for Low Income Subsidy (LIS) through the Social Security Administration and if there is no break in coverage.
- Can also switch plans if moving out of plan’s service area, lose other creditable prescription drug coverage or live in an institution, (like a nursing home).

The Gap or “Doughnut Hole”

- The coverage gap begins when the drug plan has spent a certain amount for covered drugs, ($2,930.00 in 2012)
- During the gap in 2012, covered brand name drugs are discounted by 50% of full cost, and covered generic drugs are discounted by 86% of full cost.
- When out-of-pocket expenses reach $4,700, the plan converts to Catastrophic Coverage.
- During Catastrophic Coverage, member pays $2.60 for generics and $6.50 for brand name drugs until the end of the calendar year.
- If under Extra Help, these costs won’t apply.
- The Doughnut Hole will close in 2020.
Saving money with Low Income Subsidies or “Extra Help”

- LIS or “Extra Help” assists beneficiaries with Part D premiums, deductibles and lowers drug copays.
- Eligibility is determined by income and size of the household, (i.e. single, married, supporting other relatives).
- Application processed by the Social Security Administration.
- Prescription costs as low as $2.60 for generic drugs and $6.50 for brand name drugs.

Saving Medicare Beneficiaries Money with MSPs

**Medicare Savings Programs**

- Eligibility determined through Division of Welfare and Supportive Services.
- Must be a Medicare recipient and meet income and resource requirements (Single: $8180, Couple: $11,520).
- QMB – 100% FPL or less, pays Part B premiums ($99.90 in 2012), copays, coinsurance and annual deductibles. ($1,156.00 for Part A and $140.00 for Part B in 2012).
- SLMB – 120% of FPL or less, pays for Part B premiums only ($99.90 in 2012).
- QI1 – 135% of FPL or less, pays for Part B premiums only ($99.90 in 2012).
Medigap Policies – Medicare “Supplemental” Insurance

Medigap policies are:
• Private health insurance for individuals
• Sold by private insurance companies
• Licensed by the state
• Supplements Original Medicare
• Pays share of Medicare-covered services
• Some plans may cover extras
• Follow Federal/state laws that protect Medicare Beneficiaries
• Often called “Supplemental” policies

Medigap Policies - Continued

What is Not Covered
• Most Medigap policies don’t cover things not covered by Original Medicare
• Long-term care
• Vision care and eyeglasses (in most cases)
• Dental care
• Hearing aids
• Private-duty nursing
• Outpatient prescription drugs (limited exceptions)
Medigap Policies - Continued

<table>
<thead>
<tr>
<th>Medigap Benefits</th>
<th>Medigap Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A Coinsurance</td>
<td>A  B  C  D  F*  G  K  L  M  N</td>
</tr>
<tr>
<td>Up to 365 Days</td>
<td>✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓</td>
</tr>
<tr>
<td>Part B Coinsurance</td>
<td>✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓</td>
</tr>
<tr>
<td>Blood</td>
<td>✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓</td>
</tr>
<tr>
<td>Hospice Care Coinsurance</td>
<td>✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓</td>
</tr>
<tr>
<td>Skilled Nursing Coinsurance</td>
<td>✓  ✓  ✓  ✓  50%  75%  ✓  ✓  ✓  ✓</td>
</tr>
<tr>
<td>Part A Deductible</td>
<td>✓  ✓  ✓  ✓  50%  75%  50%  ✓  ✓  ✓</td>
</tr>
<tr>
<td>Part B Deductible</td>
<td>✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓</td>
</tr>
<tr>
<td>Part B Excess Charges</td>
<td>✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓</td>
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<tr>
<td>Foreign Travel Emergency (Up to Plan Limits)</td>
<td>✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓  ✓</td>
</tr>
</tbody>
</table>

*Plan F has a high-deductible option
**Plans K and L have out-of-pocket limits of $4,640 and $2,320 respectively

Nevada Medicaid

- Medical assistance for certain individuals and families with low incomes and resources.
- There are many Medicaid programs that cover different populations according to income, resources and age.
  - TANF-Related Medicaid – cash assistance
  - Child Health Assurance Program – health insurance for kids
  - Emergency Medical Coverage – medical care for emergency situations
Medicaid Programs continued

- Nevada Check Up – low cost health insurance for kids
- Breast & Cervical Cancer Program – serves women with cancer
- Medicaid for the Aged, Blind, and Disabled (MAABD)
- Medicare Savings Programs for Medicare beneficiaries

Emergency Medical

- Must meet all eligibility criteria as all other programs (i.e. income and resources)
- Do not have to meet citizenship criteria
- Must have an emergency medical situation. Examples could be an unexpected surgery or hospitalization or delivery of a baby.
- Eligible for coverage of emergency services only.
Medicaid for the Aged, Blind and Disabled (MAABD)

The MAABD Program is medical assistance for persons who are aged, blind or disabled AND meet the financial and resource requirements for one of the eligible categories.

**QMB ONLY:**
- Coverage begins the first of the month following the month an eligibility decision is made.
- Example: Client applies November 11th. The eligibility decision is made in December. QMB coverage begins effective January 1st and ongoing.

**SLMB AND QUALIFIED INDIVIDUALS:**
- Assistance begins the first day of the month for which a person is determined eligible. There is no partial month eligibility.

Medicare Savings Program

Individuals and married couples meeting income and resource levels may qualify for Medicare Savings Programs (MSP).

MSP pays for Medicare Part A yearly deductible ($1156 in 2012), Part B monthly premiums ($99.90 in 2012) and copays for those who qualify.
MSP Eligibility Guidelines

**Qualified Medicare beneficiaries (QMB)**
The benefit is an increase in the monthly check $99.90 and not required to pay annual deductibles for Part A, Part B or co-pays.
Income limits: $908.00 – Individual, $1226.00 – Couple

**Special low-income Medicare beneficiaries (SLMB)**
The benefit is an increase in their monthly check of $99.90.
Income Limits: $1089.00 - Individual, $1471.00 - Couple

**Qualified Individuals (QI)**
The benefit is an increase in their monthly check of $99.90.
Income Limits: $1226.00 - Individual, 1655.00 - Couple

**Resources Limits:**
Must be under $6,680 for individuals and under $10,020 for couples.

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Medicaid application assistance

- Local Family Resource Centers are ready, willing and able to help with the process.
- Call Medicaid Customer Service at 775-684-7200 for help with questions.
- Statewide number for Medicaid Customer Service is 800-992-0900.
- Call Access to Healthcare Network HelpLine at 877-385-2345 to request an application by mail.
- Go to [www.dwss.nv.gov](http://www.dwss.nv.gov) to download an application from the Nevada State Welfare website.
Nevada Medicaid FAQs

- Does Nevada Medicaid cover prior bills?
- What happens if there is more than one family in a household?
- Does filling out an application affect an applicant’s immigration status?
- How do applicants prove they are legal U.S. citizens?
- Do applicants need to fill out all sections of the application?

Thank you for joining us today and for the great work you do for the most vulnerable members of our community!

**Contact Information:**
Lupe Garcia, Enrollment and Eligibility Specialist
Access to Healthcare Network
Statewide Telephone Number: 1-877-385-2345
Reno Number: 775-284-8989 x213
Website: www.accesstohealthcare.org
**FREQUENTLY ASKED QUESTIONS**

What is a benefit period?

Coverage for care in hospitals and skilled nursing facilities is measured in "benefit periods." In each benefit period, there are limits to the number of days Medicare will help pay for inpatient hospital, skilled nursing facility or hospice care. Once the limit is exceeded, the beneficiary is responsible for all charges for each additional day of care.

A benefit period begins the day of admission to a hospital. It ends when the beneficiary has been out of a hospital or skilled nursing facility for 60 straight days, including the day of discharge. A beneficiary must pay the inpatient hospital deductible for each benefit period. The benefit period also ends for those in a skilled nursing facility who have not received skilled nursing care for 60 straight days.

Once a benefit period has ended, a new benefit period begins and hospital and skilled nursing facility benefits are renewed. There is no limit to the total number of benefit periods.

What are lifetime reserve days?

60 non-renewable days that can be used over and above the 90 covered days of hospitalization during a benefit period. For instance, a beneficiary who stays in the hospital 95 days during a benefit period may elect to use 5 of his/her 60 lifetime reserve days, permanently reducing the total reserve days to 55.

What happens if I don’t enroll in Medicare when I turn 65?

- If you don’t take Part B when first eligible, you may have to wait to sign up during the annual General Enrollment Period (GEP) which runs from January 1 through March 31 of each year. Your coverage will be effective July 1 of that year.
- Premium penalty – If you don’t take Part B when you are first eligible, you will have to pay a premium penalty of 10% for each full 12-month period they could have had Part B but didn’t sign up for it, except in special situations. In most cases, they will have to pay this penalty for as long as you have Part B.

What if I’m still working and have insurance through my employer?

When your employment ends, and you are not enrolled in Part B, three things can happen:

- You may get a chance to elect COBRA coverage, which continues your health coverage through the employer’s plan (in most cases for only 18 months) and probably at a higher cost to you.


*California Health Advocates Fact Sheet Medicare and Veterans Admin. Medical Benefits Package.*
• You may get a special enrollment period to sign up for Part B without a penalty. This period will run for 8 months and begins the month after your employment ends. This period will run whether or not you elect COBRA. If you elect COBRA, don’t wait until your COBRA ends to enroll in Part B. If you enroll in Part B after the 8-month special enrollment period, you may have to pay a late enrollment penalty and you will have to wait until the next general enrollment period to enroll.

• You have a 6-month Medigap open enrollment period which gives you a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can’t be delayed or repeated.

How do I pay for the Part B Premium?

It can be deducted from:

• Social Security payments
• Railroad retirement
• Federal retirement payments

If not deducted:

• Billed every 3 months
• Medicare Easy Pay to deduct from bank account

What if I have TRICARE for Life?

• If retired you must have Part B to keep TRICARE
• Active-duty member, spouse or dependent child, you don’t have to have Part B to keep TRICARE
• You get a Part B special enrollment period if you have Medicare because you are age 65 or because you are disabled

What if I have VA benefits?

Veterans who do not enroll in Medicare Part B must go to VA facilities for their entire outpatient medical services such as doctor visits preventive care, and durable medical equipment. If they decide to enroll in Medicare Part B plan later, they would have to pay the late enrollment penalty, which is 10% of the current Part B premium for every 12-month period. They may enroll only during the General Enrollment Period, January 1 to March 31 every year, and their Part B would become effective the following July 1.

Veterans who do not enroll in a Medicare Part D plan must fill their prescriptions only at VA pharmacies. If they decide later to enroll in a Medicare Part D plan, they may enroll only during the Annual Election Period, October 15 to December 7 every year, and the plan would be effective the following January 1. They would not have to pay the late enrollment penalty because the VA prescription drug coverage is creditable. *


*California Health Advocates Fact Sheet Medicare and Veterans Admin. Medical Benefits Package.
# Medicaid (MSP) Benefits 2012

<table>
<thead>
<tr>
<th>MSP</th>
<th>QMB Full/Dual 0-78% FPL</th>
<th>QMB (Qualified Medicare Beneficiary) 79%-100% FPL</th>
<th>SLMB (Special Low Income Beneficiary) 100%-120% FPL</th>
<th>QI1 (Qualified Individual 1) 120%-135% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>Full Medicaid/Dual Eligible</td>
<td>Full Medicaid coverage</td>
<td>Medicare Part B Premium only</td>
<td>Medicare Part B premium only</td>
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<tr>
<td><strong>Individual Monthly Income</strong></td>
<td>$0-710.40</td>
<td>$710.41 - $908</td>
<td>$908.01 - $1089</td>
<td>$1,089.01 - $1,225</td>
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<tr>
<td><strong>Individual Resources</strong></td>
<td>$2000</td>
<td>$6,680</td>
<td>$6,680</td>
<td>$6,680</td>
</tr>
<tr>
<td><strong>Couple Monthly Income</strong></td>
<td>$0-$1,085.46</td>
<td>$1,085.47 – 1,226</td>
<td>$1,226.01 - $1,471.00</td>
<td>$1,471.01 - $1,655</td>
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<tr>
<td><strong>Couple Resources</strong></td>
<td>$3000</td>
<td>$10,020</td>
<td>$10,020</td>
<td>$10,020</td>
</tr>
<tr>
<td><strong>Part A Deductible ($1156 annual deductible)</strong></td>
<td>Beneficiary pays $0</td>
<td>Beneficiary Pays $0</td>
<td>Beneficiary pays $1,156</td>
<td>Beneficiary pays $1,156</td>
</tr>
<tr>
<td><strong>Part B Premium ($99.90)</strong></td>
<td>Beneficiary pays $0</td>
<td>Beneficiary Pays $0</td>
<td>Beneficiary pays $0</td>
<td>Beneficiary pays $0</td>
</tr>
<tr>
<td><strong>Part B Deductible ($140 annual deductible)</strong></td>
<td>Beneficiary pays $0</td>
<td>Beneficiary pays $0</td>
<td>Beneficiary pays $140</td>
<td>Beneficiary pays $140</td>
</tr>
<tr>
<td><strong>Part B Co-Insurance/Co-pays (Original Medicare)</strong></td>
<td>Beneficiary pays $0</td>
<td>Beneficiary pays $0</td>
<td>Beneficiary pays 20%</td>
<td>Beneficiary pays 20%</td>
</tr>
</tbody>
</table>
### Low Income Subsidy 2012

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>LIS Group 1 0%-100% FPL</th>
<th>LIS Group 2 100%-135% FPL</th>
<th>LIS Group 3 135%-140% FPL</th>
<th>LIS Group 4 140%-145% FPL</th>
<th>LIS Group 5 145%-150% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>100% LIS Subsidy Single: $908 or less Couple: $1,226 or less</td>
<td>100% LIS Subsidy Single: $908-$1,225 Couple: $1,226-$1,655</td>
<td>75% LIS Subsidy Single: $1,226-$1,271 Couple: $1,655-$1,716</td>
<td>50% LIS Subsidy Single: $1,271-$1,316 Couple: $1,716-$1,777</td>
<td>25% LIS Subsidy Single: $1316-$1362 Couple: $1,777-$1,838</td>
</tr>
<tr>
<td><strong>LIS Resource Limits</strong></td>
<td>Individual $12,640, Couple $25,260</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low Income Subsidy Part D Prescriptions Monthly premium</strong></td>
<td>Beneficiary pays $0 if enrolled in Benchmark, LIS pays up to $22.97 for non-Benchmarks</td>
<td>Beneficiary pays $0 if enrolled in Benchmark, LIS pays up to $22.97 for non-Benchmarks</td>
<td>Beneficiary pays 25% of Part D premium</td>
<td>Beneficiary pays 50% of Part D premium</td>
<td>Beneficiary pays 75% of Part D premium</td>
</tr>
<tr>
<td><strong>Low Income Subsidy Part D Prescriptions $310 annual deductible</strong></td>
<td></td>
<td></td>
<td>Beneficiary pays $65</td>
<td></td>
<td></td>
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<tr>
<td><strong>Low Income Subsidy Co-insurance up to $4,550 out of pocket</strong></td>
<td></td>
<td></td>
<td>Beneficiary pays 15% of the cost of medication</td>
<td></td>
<td></td>
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<tr>
<td><strong>Coverage Gap/Donut Hole ($2840 - $4,550)</strong></td>
<td>Beneficiary pays $0</td>
<td>Beneficiary pays 5% co-insurance</td>
<td>Beneficiary pays 50% of brand-name meds and 86% of generic for co-insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Catastrophic Coverage (After Donut Hole) $6,447.50+</strong></td>
<td>Beneficiary pays $0</td>
<td>Beneficiary pays $0</td>
<td>Beneficiary pays $2.60-$6.50 or 5% whichever is less for co-pay</td>
<td>Beneficiary pays $2.60 for those generic or preferred multisource drugs with a retail price under $52 and 5% for those with a retail price greater than $52. As to Brand drugs, beneficiaries would pay $6.50 for those drugs with a retail price under $130 and 5% for those with a retail price over $130.</td>
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<tr>
<td><strong>Senior Rx/Disability Rx (SPAP)</strong></td>
<td></td>
<td></td>
<td></td>
<td>Pays up to $20.56 toward Part D premium per month. $10 for generics, $25 for brand names if not eligible for Part D No payment in donut hole Benefits limit: maximum benefit per year is $5,100</td>
<td></td>
</tr>
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</table>

Rev. 12/2011
Four Parts of Medicare

Part A  
Hospital Insurance

Part B  
Medical Insurance

Part C  
Medicare Advantage

Part D  
Medicare Prescription Drug Coverage

04/28/2011  
Understanding Medicare  
9
### If Not Automatically Enrolled Your 7-Month Initial Enrollment Period

<table>
<thead>
<tr>
<th>No Delay</th>
<th>Delayed Start</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you enroll in Part B</strong></td>
<td><strong>The month you turn 65</strong></td>
</tr>
<tr>
<td>3 months before the month you turn 65</td>
<td>1 month after you turn 65</td>
</tr>
<tr>
<td>2 months before the month you turn 65</td>
<td>2 months after you turn 65</td>
</tr>
<tr>
<td>1 month before the month you turn 65</td>
<td>3 months after you turn 65</td>
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</tbody>
</table>

Sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during the first three months before the month you turn 65.

If you wait until the last four months of your Initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed.
# Paying for Inpatient Hospital Stays

<table>
<thead>
<tr>
<th>For each benefit period in 2012</th>
<th>You Pay</th>
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<tbody>
<tr>
<td>Days 1-60</td>
<td>$1,156 deductible</td>
</tr>
<tr>
<td>Days 61-90</td>
<td>$289 per day</td>
</tr>
<tr>
<td>Days 91-150</td>
<td>$578 per day</td>
</tr>
<tr>
<td></td>
<td>(60 lifetime reserve days)</td>
</tr>
<tr>
<td>All days after 150</td>
<td>All Costs</td>
</tr>
</tbody>
</table>

04/28/2011

Understanding Medicare

14