# 2026 MEDICARE PART A

($0 premium-40 QTRS - $311 30-39 QTRS - $565 <30 QTRS)

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

| Hospitalization Time | Medicare Covers | You pay | You Pay with Plan F | You Pay with Plan G | You Pay with Plan N |
|---|---|---|---|---|---|
| **1-60 days** | Most confinement costs after the required Medicare deductible. | **$1,736.00 Part A Deductible** | **$0** | **$0** | **$0** |
| **61-90 days** | All eligible expenses after patient pays a per-day copayment. | **$434 Day Copayment as much as $13,020** | **$0** | **$0** | **$0** |
| **91-150 days** | All eligible expenses after patient pays a per-day copayment (These are Reserve Days that may never be used again). | **$868 Day Copayment as much as $52,080** | **$0** | **$0** | **$0** |
| **151 days +** | N/A | **You Pay All Costs** | **$0** | **$0** | **$0** |
| **SKILLED NURSING CONFINEMENT:** Following an inpatient hospital stay of at least 3 days and enter a Medicare-Approved facility within 30 days after hospital dischar and receive skilled nursing care. | All eligible expenses for the first 20 days; then all elivgible expenses for 21-100 days after patient pays a per day copayment. | **After 20 Days $217 Copayment as much as $17,440** | **$0** | **$0** | **$0** |

**NOTES:**

# 2026 MEDICARE PART B

($202.90 premium <109k - (up to $689.90 based on income)

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

| On Expenses Incurred For: | Medicare Covers | You pay | You Pay with Plan F | You Pay with Plan G | You Pay with Plan N |
|---|---|---|---|---|---|
| **Annual Deductible** | Incurred expenses after the required Medicare deductible. | **$283 Annual Deductible** | **$0** | **$283 Annual Deductible** | **$283 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** | **$0** | **$0** | **Up to $20/$50 Copays $50 Emergency visit copay WAIVED if admitted** |
| **Clinical Lab Services** Blood tests, urinalysis. | Generally **100%** of approved amount. | **Nothing for services** | **$0** | **$0** | **$0** |
| **Home Health Care** Part-time or intermittent skilled care; home health aid services; durable medical supplies; and other services. | **100%** of approved amount **80%** of approved amount for durable medical equip. | **Nothing for services 20% of approved amount* for durable med equip** | **$0** | **$0** | **$0** |
| **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** | **$0** | **$0** | **$0** |
| **Blood** | **80%** of approved amount after first 3 pints. | **First 3 pints plus 20% of approved amount for additional pints** | **$0** | **$0** | **$0** |
| **Excess Doctor Charges** Above Medicare-approved amount. **(Max 115%)** | **0%** above approved amount. | **All Costs** | **$0** | **$0** | **All Costs** |

**Age:** _____ **T/NT:** _____ **Current Carrier:** _____ _____ _____ _____

**M/F:** _____ **Phone Number:** _____ **Carrier:** _____ _____ _____ _____