McMillan AGENCY

Your GUIDE to RETIREMENT

2023
Medicare Survival Guide
Part 1

INSIDE

What to Know About Medicare for 2023

Social Security Bonus Section

Guide to Nontaxable Retirement Income

Full or partial Roth conversions can be a powerful tool for gaining control over taxes, managing future Required Minimum Distribution payments, and establishing a nontaxable income[1] stream in retirement.

Our Partial Roth Conversion Guide walks through a simple three step process for using an annuity to convert funds into nontaxable distributions[1] from a Roth IRA.

Call to request your client-approved Partial Roth Conversion Guide.

[1]Assuming distributions taken are Qualified Distributions as defined by the IRS.

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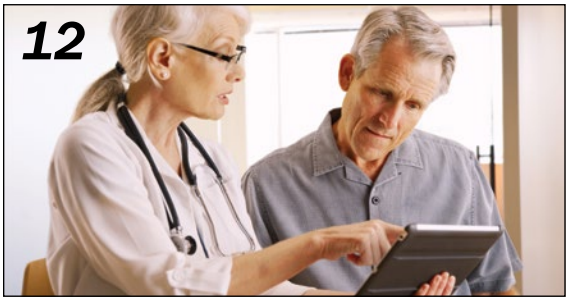

Make Sure You Also Grab Part 2 of the 2023 Medicare Survival Guide!

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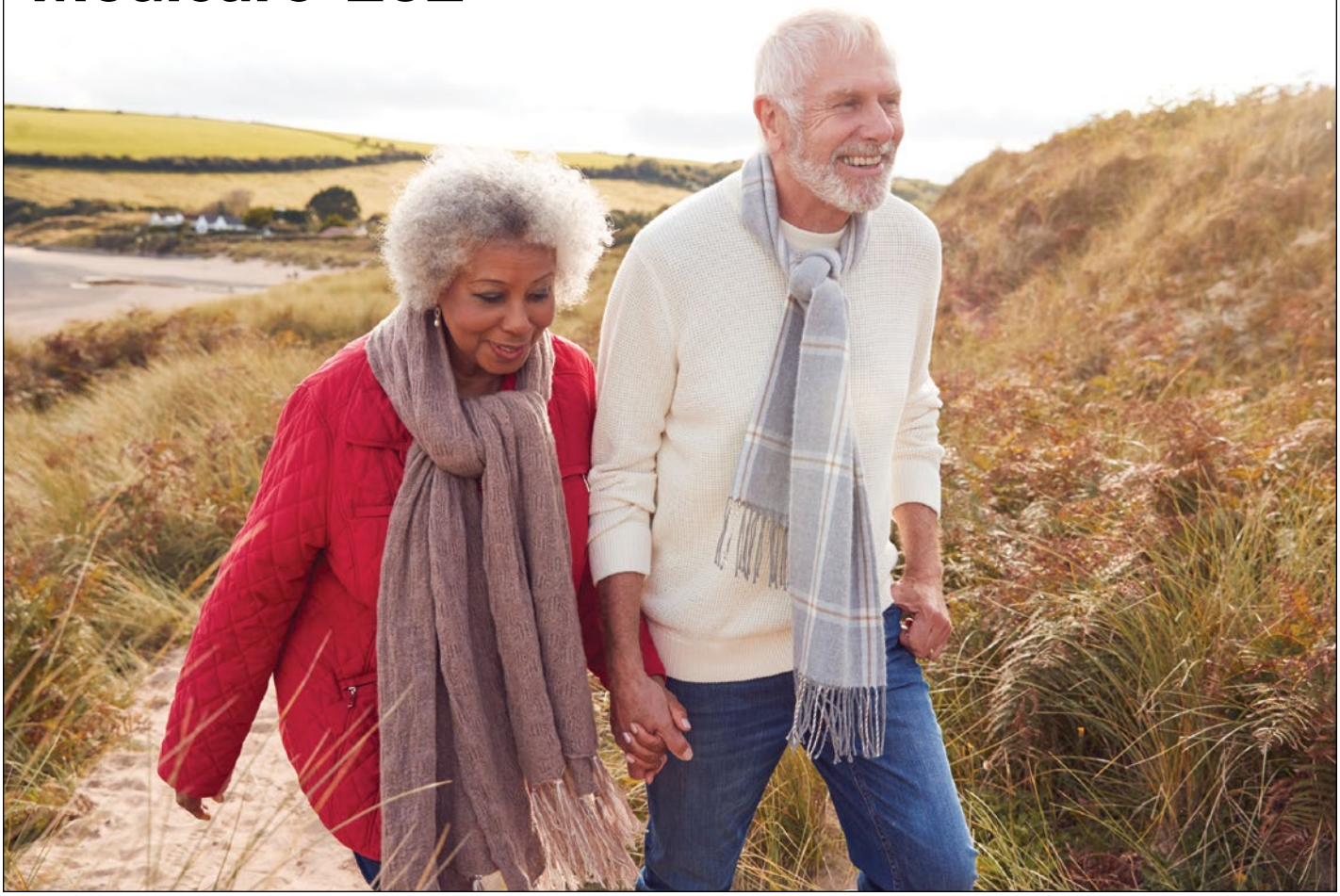
Medicare 101



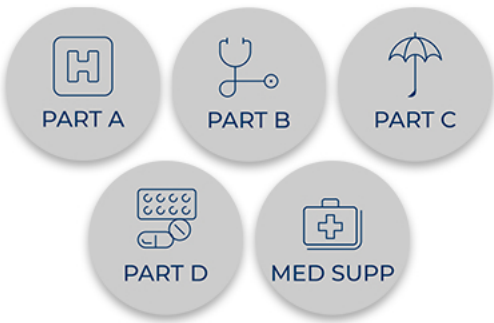
At first glance, Medicare can seem quite confusing. Having a solid foundation of knowledge on the most basic parts of the Federal Healthcare program can assist in making an educated decision when it comes to managing your benefits.

Building Blocks of Medicare

Medicare health coverage has five parts that you need to know about. **Part A** - inpatient hospital and facility benefits;

Part B - physician and outpatient benefits;

Part C/Medicare Advantage - a combination of Part A, Part B, and sometime Part D; **Part D** - prescription drug coverage; and **Medicare Supplements,** to fil in the gaps of Parts A and B.



Medicare Eligibility

To be eligible for Part A and Part B, also referred to as "Original Medicare", you must be a U.S citizen or legal resident for at least 5 consecutive years **AND** one of the following: age 65 or older, under 65 with a qualifying disability, or any person diagnosed with end-stage renal disease or ALS (Lou Gehrig's Disease).

Gaps in Medicare

While Medicare Part A and Part B provide great financial protection, there are still gaps in the coverage you need to be aware of. Both Part A and Part B have premiums, deductibles, and cost sharing for services with no out-of-pocket limit, and can have limits on services or items that would not be covered.

Healthcare Coverage Options

To cover the gaps in Medicare Part A and Part B, there are a few options you can consider.

STEP 1 Enroll in Original Medicare.

STEP 2 Decide if you need additional coverage. You have two ways to get it.

Original Medicare
Provided by the government

- **Part A** covers hospital stays
- **Part B** covers doctor and outpatient visits

OPTION 1
Add one or both of the following to Original Medicare

Medicare Supplement
Offered by private companies

- Covers some of the costs not paid by Original Medicare Parts A and B

Medicare Part D
Offered by private companies

- Covers prescription drugs

OR

OPTION 2
Choose a Medicare Advantage plan

Medicare Advantage
Offered by private companies

- **Part C** combines Part A (hospital) and Part B(doctor)
- Provides aditional benefits
- **Part D** covers prescription drugs

Medicare Part A

Medicare Part A – Qualifications and Coverage

When Medicare was created in 1965, the first two parts offered were A (hospital insurance) and B (medical insurance). The qualifications for these initial programs were fairly simple:

- Age 65 or older
- U.S. citizen or permanent legal resident
- Under age 65 with certain disabilities, like Lou Gehrig's disease or End Stage Renal Disease (ESRD)

Unbeknownst to many, Part A does have a monthly premium like Part B, but because of some rules surrounding employment and tax history, many beneficiaries do not pay a premium.

- No premium for individuals that have worked at least 40 quarters (10 years) while paying Medicare taxes from their wages. These 40 quarters do not need to be worked consecutively, but cumulatively over their life. If an individual turns 65 and does not have 40 quarters but is still working, once they hit the 40 quarter threshold their premium for Part A will be eliminated
- Worked 0-29 quarters – they'd pay $499/month in 2022
- Worked 30-39 quarters – they'd pay $274/month in 2022

Medicare Part A, also known as hospital insurance, goes above and beyond it's name to cover many services, including:

- Inpatient hospitalization – NOTE: outpatient hospitalization and/or observation stays are covered under Medicare Part B
- Skilled nursing facility care
- Home health care
- Hospice care

Inpatient Hospitalization Qualifications

Part A covers inpatient hospitalizations if the beneficiary meets both conditions:

- They're admitted to the hospital as an inpatient after an official doctor's order, which says they need inpatient hospital care to treat their illness or injury, and
- The hospital accepts Medicare

In certain cases, Part A also covers inpatient hospital care if the hospital's Utilization Review Committee approves their stay while they're admitted

Inpatient Hospitalization Coverage

Medicare-covered inpatient hospital services include:

- Semi-private rooms
- Meals
- General nursing
- Drugs – NOTE: any maintenance medication the beneficiary is currently on cannot be brought into the hospital, and will be administered from the hospital's in-house pharmacy to the client. These medications, called self-administered drugs, are not covered under Part A nor Part D.
- Other hospital services and supplies as part of their inpatient treatment Medicare does not cover any of the following during an inpatient hospitalization:
- Private-duty nursing
- Private room (unless medically necessary)
- Television or phone in your room (if there's a separate charge)
- Personal care items, like razors, slipper socks, etc.

Inpatient Hospitalization Benefit Period

The coverage and costs associated with an inpatient hospital stay are based on what Medicare calls a benefit period. A benefit period begins the day the beneficiary is formally admitted as an inpatient and ends when they haven't received any inpatient hospital or skilled nursing facility care for 60 days in a row.

For example, if they were in the hospital as an inpatient and were discharged for 30 days then are re-admitted (even if for a different illness/injury), they are still within their previous benefit period and their Medicare benefits would pick up where they left off.

Inpatient Hospitalization Costs

The beneficiary's costs for each benefit period are:

- $1,556 deductible – this covers them for the first 60 days in the hospital
- Days 1-60: $0 copay
- Days 61-90: $389 copay per day
- Days 91 and beyond: $778 per day
    - o NOTE: These are considered Lifetime Reserve Days. Each beneficiary has a total of 60 Lifetime Reserve Days they can use throughout their life. After those days have been depleted, the maximum days that Medicare will cover for an inpatient hospitalization is capped at 90.
- Each day after Lifetime Reserve days are depleted: the beneficiary would be responsible for all costs

Skilled Nursing Facility Care Qualifications

Medicare Part A covers skilled nursing care in a skilled nursing facility (SNF) for a limited time (on a short-term basis) if all these conditions apply:

- They have part A and have days left in their benefit period to use
- They have a qualifying inpatient stay (3 day minimum, more on that later)
- Their doctor has decided that they need daily skilled care. They must get care from, or under the supervision of, skilled nursing or therapy staff
- They get these skilled services in a Medicare-certified SNF facility
- They need these skilled services for a condition that's either:
    - o A hospital-related medical condition treated during their qualifying 3-day inpatient hospital stay (not including the day they were discharged), even if it wasn't the reason they were admitted to the hospital, or
    - o A condition that started while they were getting care in the SNF for a hospital-related medical condition (for example, if they develop an infection that requires IV antibiotics while they're getting SNF care)

Skilled Nursing Facility Care Coverage

Medicare-covered services in a SNF include, but are not limited to:

- A semi-private room (a room they share with other patients)
- Meals
- Skilled nursing care
- Physical Therapy
- Occupational Therapy
- Speech-language pathology services
- Medical social services
- Medications
- Medical supplies and equipment used in the facility
- Ambulance transportation
- Dietary counseling

Continued on Page 8

Continued from Page 7

Skilled Nursing Facility Care Costs

Beneficiaries pay the following for each benefit period (same as inpatient):

- Days 1-20: $0 copay, Medicare covers all charges
- Days 21-100: up to $194.50 per day
- Days 101 and beyond: the beneficiary pays all costs

On page 55 of the 2022 Medicare & You handbook, they specifically state that Original Medicare does not cover the cost of long term care. Medicare will pay for skilled care needed in a facility as part of the recovery from an illness or injury, they will not pay for any long term care services that usually include custodial or non-skilled personal care. Based on many surveys from Medicare beneficiaries, there is a false expectation that Medicare covers LTC services, that's why almost an entire page in the Medicare & You handbook is dedicated to dispelling this myth, and is important for beneficiaries to understand.

Home Health Care Qualifications

All people with Part A and/or Part B who meet all of these conditions are covered:

- They must be under the care of a doctor, and they must be getting services under a plan of care created and reviewed regularly by a doctor
- They must be homebound, and a doctor must certify that they're homebound. Medicare's definition of "homebound" is based on the following criteria:
  - **Criteria 1** – One of these conditions must be met:
    - Because of illness or injury, they need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the user of special transportation; or the assistance of another person to leave their place of residence, or
    - Have a condition such that leaving their home is medically contraindicated (not advised by medical professionals)
  - **Criteria 2** – Both of these conditions must be met:
    - There must exist a normal inability to leave home, and
    - Leaving home must require a considerable and taxing effort
- They must need, and a doctor must certify that they need, one of more of these:
  - o Intermittent skilled care (other than drawing blood)
  - o Physical therapy, speech language pathology, or continued occupational therapy services. The amount, frequency, and time period of these services needs to be reasonable, and they need to be complex or only qualified therapists can do them safely and effectively
  - o To be eligible, either:
    - Their condition must be expected to improve in a reasonable and generally predictable period of time, or
    - They need a skilled therapist to safely and effectively make a maintenance program for their condition, or
    - They need a skilled therapist to safely and effectively do maintenance therapy for their condition
  - o The home health agency caring for them must be approved by Medicare

Home Health Care Coverage

Medicare covers all approved home health care services. Medicare, however, does not pay for:

- 24-hour-a-day care at their home
- Meals delivered to their home
- Homemaker services (like shopping, cleaning, and laundry) that aren't related to their care plan
- Custodial or personal care that helps them with the activities of daily living, like bathing, dressing, or using the bathroom, when this is the only care they need

Home Health Care Costs

A beneficiary's costs for Medicare-approved home health care services are:

- $0 for covered services
- After they've met the Part B deductible, 20% of the Medicare-approved amount for covered medical equipment in the home (if needed)

This may seem like a generous benefit, but remember, for Medicare to approve the Home Health Care services there are strict limits on coverage for skilled care only, intermittent care, and there must be a reasonable expectation that the beneficiary will improve, and the care will not be needed for an unreasonable amount of time.

Hospice Care Qualifications

Beneficiaries qualify for Medicare-covered hospice care if they have Medicare Part A and meet all of these conditions:

- Their hospice doctor and their regular doctor (if they have one) certify that they're terminally ill with a life expectancy of 6 months or less, and
- The beneficiary accepts comfort care (palliative care) instead of care to cure their illness, and
- They sign a statement choosing hospice care instead of other Medicare-covered treatment for their terminal illness and related conditions

Hospice Care Coverage

Depending on their illness, their hospice team will create a plan of care that can include any or all of these services:

- Doctor's services
- Nursing and medical services
- Durable medical equipment and supplies
- Drugs for pain management, spiritual and grief counseling for them and their family
- Any other services Medicare covers to manage their pain and other symptoms

Hospice Care Costs

Medicare beneficiaries generally pay nothing for Medicare-covered hospice care, but there are some costs that can present themselves:

- They pay a copayment up to $5 for each prescription for outpatient drugs for pain and symptom management
- They may have to pay room and board if they live in a facility, like a nursing home, and choose to get hospice care there
- They may pay 5% of the Medicare-approved amount for inpatient respite care
    - o Inpatient respite care is temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is their primary caregiver can rest or take some time off.

Online Resources

To help beneficiaries find and compare hospitals, nursing homes, and hospice care that are accepted by Medicare, they should visit www.medicare.gov/care-compare. This is a easy to navigate site to see who's part of the program and how they're rated.

Medicare Part B

Medicare Part B – Qualifications and Premium

When Medicare was created in 1965, the first two parts offered were A (hospital insurance) and B (medical insurance). The qualifications for these initial programs were fairly simple:

- Age 65 or older
- U.S. citizen or permanent legal resident
- Under age 65 with certain disabilities, like Lou Gehrig's disease or End Stage Renal Disease (ESRD)

Unlike Part A which many beneficiaries do not pay a premium for, most Part B recipients pay a monthly premium. In 2022, the Standard Part B premium is $170.10 per month, however, if their Modified Adjusted Gross Income (MAGI) is above a certain amount, they'll pay an additional Income Related Monthly Adjustment Amount (IRMAA). This premium upcharge is not based on their projected income for the current calendar year, but on their MAGI from their taxes filed two years ago (i.e., in 2022, their IRMAA is based on their 2020 tax returns).

If your yearly income in 2020 was:			You pay each month (in 2022)
File individual tax return	File joint tax return	File married & separate tax return	
$91,000 or less	$182,000 or less	$91,000 or less	$170.10
$91,001 up to $114,000	$182,001 up to $228,000	Not applicable	$238.10
$114,001 up to $142,000	$228,001 up to $284,000	Not applicable	$340.20
$142,001 up to $170,000	$284,001 up to $340,000	Not applicable	$442.30
$170,001 up to $500,000	$340,001 up to $750,000	$91,001 up to $409,000	$544.30
$500,000 or above	$750,000 or above	$409,000 or above	$578.30

Medicare Part B – Coverage

Part B, also known as medical insurance, is the most used benefit in Original Medicare. Essentially, Part B covers two main categories:

- Medically necessary services – services or supplies that are needed to diagnose or treat their medical condition
- Preventive services – healthcare to prevent illness or detect it at an early stage, when treatment is mot likely to work best

For medically necessary services, there are so many things that are covered it's hard to list them all, but this presentation does include a slide with some of the more common items/services that Medicare covers, according to their website. You can break down the medically necessary services into basic categories:

- Doctor and other healthcare provider services
- Durable medical equipment
- Diagnostic testing & imaging
- Outpatient hospital services
- Therapy
- Emergency & urgent care
- Chemotherapy & dialysis

Up until 2010, Medicare had limited benefits for preventive services and would focus more of its coverage on treating acute and chronic conditions that beneficiaries were already dealing with. With the passing of the Affordable Care Act, Medicare now covers a wide array of preventive services (as seen on slide 8 of the presentation). You can find more about the individual benefits for each at www.medicare.gov/coverage/preveitve-screening-services.

For this presentation, it's important to call out the Yearly Wellness Visit as part of the preventive services. While many doctors understand Medicare does not cover a full physical each year, there are still situations where beneficiaries go in for their annual checkup and wonder why Medicare is not covering the bill. After someone has been on Part B for 12 months, Medicare will cover a "Yearly Wellness Visit", which looks a lot like a physical to your clients but is more of an in-person health risk assessment being performed in a doctor office setting. As part of the wellness visit, the doctor may:

- Review their medical and family history
- Review their current providers and prescriptions
- Check height, weight, bold pressure, and other routine measurements
- Give personalized health advice
- Review a list of risk factors and treatment options for their conditions
- Review a screening schedule (or checklist) of preventive services they should take advantage of that are covered by Part B 100%
- Perform a cognitive assessment to check for signs of dementia.

Part B Coverage – Additional Resources

Beneficiaries can search for tests, services, and items on Medicare's website to see if they'll be covered, and what criteria may need to be met (if any) for Medicare to provide benefits. www.medicare.gov/coverage. NOTE: as an agent, this is a great site to bookmark if your clients have questions on whether something will be covered by Medicare.

Also, Medicare has released their What's Covered app for smart devices, where you can easily search for tests, services, and items on the go. You can download it from the Apple App Store or the Google Play Store.

Medicare Part B – Costs

While the coverage for Part B is very broad and most frequently used, the costs associated with it are straight forward - deductible, coinsurance, and excess charges

Deductible – applies/resets each calendar year and may change from year to year. The Part B deductible for 2022 is $233 (up from $203 in 2021).

Coinsurance – after the beneficiary has satisfied the deductible each calendar year, they are responsible for 20% of the Medicare Approved Amount.

Over 95% of all doctors accept Medicare across the country, but not all of them accept Medicare Assignment. When a doctor accepts Medicare Assignment, they agree that whatever Medicare deems as their approved amount for services, is payment in full. For example, a doctor may charge

$400 for their most common procedure, but Medicare's approved amount may only be $300, and the doctor simply writes off the difference. In this example, with Medicare's approved amount at

$300, the beneficiary would be responsible for 20%, or $60.

Part B Excess Charges – for doctors who accept Medicare, but do not accept Medicare Assignment, they are allowed to charge up to 15% more than the Medicare approved amount for services and the beneficiary is 100% responsible for paying these amounts. The best way to avoid these additional charges is to make sure your provider accepts Medicare Assignment (which can be verified on www.medicare.gov/care-compare - look for the dollar sign indicator that says "charges the Medicare-approved amount (so you pay less out-of-pocket).)

There are some instances where avoiding Part B Excess Charges is unavoidable. In that case, beneficiaries may choose to have a Medicare Supplement plan that covers those charges or a Medicare Advantage plan, which does not allow for balance billing.

Part B Excess Charges

One of the most frustrating parts of Medicare Part B comes from surprise costs associated with doctors, providers, and suppliers that do not accept Medicare Assignment. This presentation educates Medicare beneficiaries on why this is important to understand, and how they can avoid any unexpected out-of-pocket costs.

Medicare Assignment

If a doctor, provider, or supplier agrees that Medicare's limiting schedule (the set amount of money that Medicare will pay for approved services) is payment in full, then they are considered to accept Medicare assignment. Those who accept Medicare assignment are called Participating, or PAR providers, within the Medicare program.

If a beneficiary sees a PAR provider for their healthcare services, this is what they can expect:

- Their out-of-pocket costs may be less (depending on Medicare's fee schedule)
- The provider agrees to charge the beneficiary only for Medicare's deductible and coinsurance amount, and they usually wait for Medicare to pay its share before asking the beneficiary to pay theirs
- Providers are required to submit the claim directly to Medicare, and cannot charge the beneficiary a cost for submitting the claim.

Needless to say, seeing a PAR provider is the best chance a beneficiary has to not only paying the lowest out of pocket costs, but to also have the smoothest experience with their claims.

Non-Participating Providers

If a doctor, provider, or supplier doesn't agree that Medicare's limiting schedule is payment in full, but still accepts Medicare insurance, they are considered Non-Participating or Non-PAR providers. These providers are not required to submit claims to Medicare on the beneficiary's be- half, and they can charge 15% higher than Medicare's fee schedule for their services (called a Part B Excess Charge), and the beneficiary is responsible for paying that additional 15%. Also, Medicare will pay the beneficiary for the services (minus their portion), and the beneficiary has to pay the provider in full directly.

If a beneficiary sees a Non-PAR provider for their healthcare services, this is what they can expect:

- Their out-of-pocket costs could be more (providers can pick and choose if they want to bill for the Part B Excess charge on each claim)
- The provider may require payment for services up front, leaving the beneficiary to file their claims directly to Medicare
- The beneficiary will be responsible for paying the provider directly, not Medicare.

Excess Charge Example

If a beneficiary sees a PAR provider for a service with a Medicare-approved amount of$100, here's how the payments will break down:

- Medicare pays 80% of the approved amount: **$80**
- Beneficiary pays 20% of the approved amount: **$20**

The beneficiary's total out-of-pocket cost is $20

If a beneficiary sees a Non-PAR provider for the same service as above, Medicare is going to reduce their fee schedule to 95% of the original amount, so $95, and the payments will break down as follows:

- Medicare pays 80% of 95% of the approved amount: **$76**
- Beneficiary pays 20% of 95% of the approved amount: **$19**
- Plus a 15% Excess Charge of 95% of the approved amount: **$14.25**

The beneficiary's total out-of-pocket cost is $33.25

With our example, the difference between the two situations is only $13.25, but that's an overall increase of 60% in out-of-pocket costs. Imagine what that could be for higher cost providers that bill the Part B Excess Charge

Prohibited States

Some states prohibit providers from billing for a Part B Excess Charge if they accept Medicare insurance. Those states are:

- Connecticut
- Massachusetts
- Minnesota
- New York (providers are limited to an Excess Charge of 5%)
- Ohio
- Pennsylvania
- Rhode Island
- Vermont

CAUTION: Medicare Supplement plans sold in MA and MN do not offer Part B Excess coverage. If beneficiaries travel outside the state to obtain services at a Non-PAR provider, they may have to pay the Part B Excess charge.

Avoiding Excess Charges

The simplest way for beneficiaries to avoid paying Part B excess charges is to find a PAR provider that accepts Medicare's assignment. Medicare has created their Care Compare search tool at www.medicare.gov/care-compare to make that process simple for beneficiaries across the country. Each PAR provider in the search tool is highlighted by a dollar sign symbol that states "Charges the Medicare-approved amount (so you pay less out-of-pocket", making is easy to identify where to seek the lowest cost healthcare in their area.

Medicare Supplement (Medigap) plans are also another great way to cover the cost of Part B Excess charges. Plans F and G provider coverage for excess charges, and in Wisconsin beneficiaries can add a rider to cover those costs when they sign up for their coverage.

Massachusetts and Minnesota supplement plans do not offer coverage for Part B Excess charges, so if they seek care outside of their state they may be required to pay the additional costs for those services.

Most Medicare Advantage plans are network based, meaning HMO or PPO plans. The best way for a HMO or PPO Medicare Advantage beneficiary to avoid paying unexpected costs is to seek care from contracted, in-network providers. These providers are not allowed to bill beneficiaries over and above their contracted amount for any covered service, keeping the client's out-of-pocket costs predictable.

Sources:

https://www.medicare.gov/your-medicare-costs/part-a-costs/lower-costs-with-assignment

https://www.medicareinteractive.org/get-answers/medicare-covered-services/outpatient-provider-services/participating-non-participating-and-opt-out-providers https://www.aafp.org/family-physician/practice-and-career/getting-paid/medicare-options.html

https://65medicare.org/medicare-part-b-excess-charges/#:~:text=In%20these%20states%2C% 20doctors%20are,%2C%20Rhode%20Island%2C%20and%20Vermont

https://www.medicare.gov/forms-help-resources/find-compare-health-care-providers

Income-Related Monthly Adjustment Amount (IRMAA)

There are situations where Medicare beneficiaries may have to pay more for their Medicare Part B and Part D coverage due to their income. This is called an Income-Related Monthly Adjustment Amount (IRMAA) and was enacted as a way to help the Medicare program stay solvent as the Baby Boomer generation became eligible for benefits. The Part B IRMAA was a result of the passing of the Medicare Modernization Ace of 2003, the same act that expanded the funding for the Medicare Advantage programs as well as created the Medicare Part D program. The Part D IRMAA was a result of the passing of the Affordable Care Act of 2010.

Eligible Income

The income used to determine a beneficiary's IRMAA is defined by Medicare as "adjusted gross income plus any tax-exempt interest", also known as the Modified Adjusted Gross Income (MAGI). Examples of eligible income include:

- Wages
- Social Security Benefits
- Capital Gains
- Dividends & Pensions
- Rental Income
- Tax-deferred distributions from 401(k)s or IRAs

It's important to note that the MAGI used to determine IRMAA is always based on tax returns from two calendar years ago. For instance, 2021 IRMAAs are based on filed tax returns from the 2019 tax year.

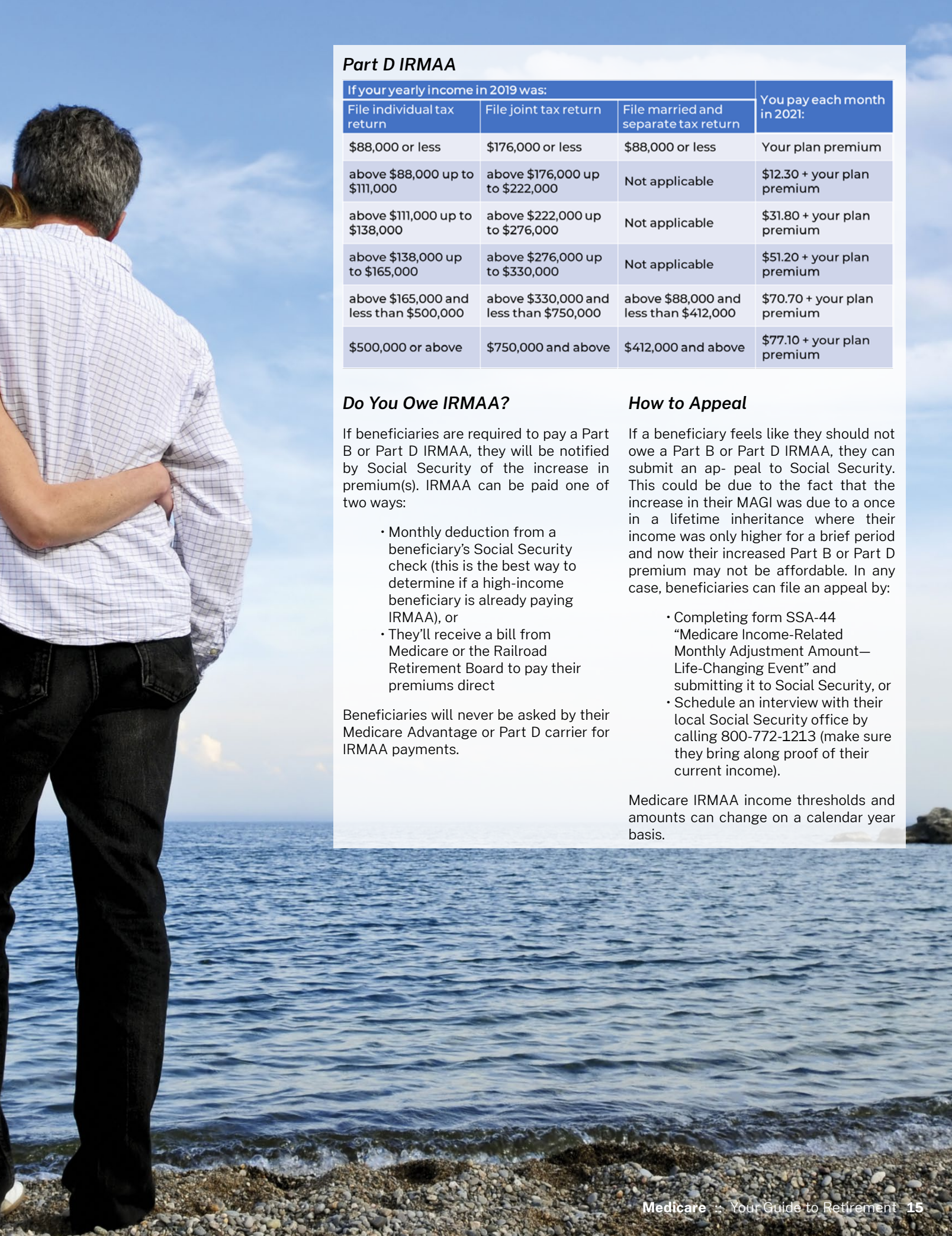
Part D premiums by income

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

2023

If your filing status and yearly income in 2021 was			
File individual tax return	File joint tax return	File married & separate tax return	You pay each month (in 2023)
$97,000 or less	$194,000 or less	$97,000 or less	your plan premium
above $97,000 up to $123,000	above $194,000 up to $246,000	not applicable	$12.20 + your plan premium
above $123,000 up to $153,000	above $246,000 up to $306,000	not applicable	$31.50 + your plan premium
above $153,000 up to $183,000	above $306,000 up to $366,000	not applicable	$50.70 + your plan premium
above $183,000 and less than $500,000	above $366,000 and less than $750,000	above $97,000 and less than $403,000	$70.00 + your plan premium
$500,000 or above	$750,000 or above	$403,000 or above	$76.40 + your plan premium

Feedback



Part D IRMAA

If your yearly income in 2019 was:			You pay each month in 2021:
File individual tax return	File joint tax return	File married and separate tax return	
$88,000 or less	$176,000 or less	$88,000 or less	Your plan premium
above $88,000 up to $111,000	above $176,000 up to $222,000	Not applicable	$12.30 + your plan premium
above $111,000 up to $138,000	above $222,000 up to $276,000	Not applicable	$31.80 + your plan premium
above $138,000 up to $165,000	above $276,000 up to $330,000	Not applicable	$51.20 + your plan premium
above $165,000 and less than $500,000	above $330,000 and less than $750,000	above $88,000 and less than $412,000	$70.70 + your plan premium
$500,000 or above	$750,000 and above	$412,000 and above	$77.10 + your plan premium

Do You Owe IRMAA?

If beneficiaries are required to pay a Part B or Part D IRMAA, they will be notified by Social Security of the increase in premium(s). IRMAA can be paid one of two ways:

- Monthly deduction from a beneficiary's Social Security check (this is the best way to determine if a high-income beneficiary is already paying IRMAA), or
- They'll receive a bill from Medicare or the Railroad Retirement Board to pay their premiums direct

Beneficiaries will never be asked by their Medicare Advantage or Part D carrier for IRMAA payments.

How to Appeal

If a beneficiary feels like they should not owe a Part B or Part D IRMAA, they can submit an ap- peal to Social Security. This could be due to the fact that the increase in their MAGI was due to a once in a lifetime inheritance where their income was only higher for a brief period and now their increased Part B or Part D premium may not be affordable. In any case, beneficiaries can file an appeal by:

- Completing form SSA-44 "Medicare Income-Related Monthly Adjustment Amount—Life-Changing Event" and submitting it to Social Security, or
- Schedule an interview with their local Social Security office by calling 800-772-1213 (make sure they bring along proof of their current income).

Medicare IRMAA income thresholds and amounts can change on a calendar year basis.

2022 Part D Basics

Before Medicare Part D was signed into law in 2003, and launched in 2006, Medicare beneficiaries had very few options to help cover the cost of their prescription medications, which were rapidly rising during that time:

- Group/union coverage
- Retiree coverage
- Medicare Supplement Plan J (only offered catastrophic coverage)
- Self-insure

Today, 77% of all Medicare beneficiaries are enrolled into a Part D plan. Part D Basics

Medicare Part D is a voluntary benefit, meaning that individuals that qualify (must have either Part A or Part B) do not have to enroll into it. It's only offered through private insurance companies and is available as either a stand-alone plan, or PDP, or combined with a Medicare Advantage plan, often referred to as MAPD (Medicare Advantage Prescription Drug). Benefits for Part D plans change each calendar year and provide coverage for both generic and brand name medications.

Enrollment

Beneficiaries can only enroll or change plans during a valid enrollment period:

- Initial Enrollment Period - 3 months before, the month of, and three months after their Part A or Part B start date (whichever comes first)
- Annual Enrollment Period - October 15 through December 7 each year. Benefits start the following January 1st
- Special Election Period - these are specific situations that can happen throughout the year, and are usually tied to a change in their current benefits. Some of the most common SEPs for Part D coverage include loss of group coverage, loss of creditable coverage (prescription coverage that's at least as good as Part D coverage), change of residence, and qualifying for Extra Help

Premiums

Premiums can vary widely for Part D coverage, depending on whether or not the beneficiary has a stand-alone Part D plan or a combined MAPD plan. All stand-alone Part D plans will have a monthly premium and will vary by carrier and state, and some MAPD plans offer coverage for a $0 monthly premium. All PDP and MAPD plans will offer three methods to pay for premiums, including:

- Automatic monthly bank draft from a checking or savings account
- Monthly coupon book
- SSA deduction. NOTE: If a beneficiary elects to pay their premium from their SSA check, they may be required to pay the first 1-2 month's premium directly to the carrier as there can be a delay in processing.

Late Enrollment Penalty

Even through Part D is a voluntary benefit, if there is a delay in coverage from when they're first eligible to sign up they could be assessed a Late Enrollment Penalty (LEP). The LEP is calculated using the "national base beneficiary premium" and will permanently be attached to the beneficiary's Part D coverage, regardless if they have a PDP or MAPD plan. For each month after their IEP has ended that there's a break in coverage of 63 or more days in a row, they will be penalized 1%. The national base beneficiary premium for 2022 is $33.37.

For example: Client went 20 months after their IEP without creditable prescription drug coverage > $33.37 x .20 (20%) = $6.67 will be added to their premium each month.

Examples of creditable coverage include employer/union group coverage, retiree coverage, VA coverage, state pharmaceutical assistance programs.

Coverage Stages

Each year the Centers for Medicare and Medicaid Services (CMS) releases a standard benefit for insurance companies to build their plans around. In the standard benefit, there are four coverage stages: deductible, initial coverage limit, coverage gap (aka donut hole), and catastrophic coverage.

The Yearly Deductible is the amount that a beneficiary must pay out of their pocket before the plan starts to pay their share for covered medications. Deductibles can vary between plans, with some plans having no deductible or limiting the deductible only to specific drug tiers. No plan may have a deductible more than $480 in 2022.

The Initial Coverage Limit (ICL) is a combination of what is spent by the beneficiary and the plan for covered medications, this amount is $4,430 in 2022. The ICL is important because it will determine if the beneficiary will pay their copay/coinsurance for their monthly prescriptions during the year or if they will enter the donut hole where coverage changes. Essentially, you can consider the ICL to be the total retail cost of the beneficiary's medications. For example - beneficiary spent $600 in copays during the ICL and the plan spent $3,830, totaling $4,430 and now the client enters the coverage gap with only $600 in out-of-pocket spending.

Coverage Gap (Donut Hole)

Once the beneficiary and the plan have spent $4,430 on covered drugs, they move into the Coverage Gap. During the coverage gap, they will pay no more than 25% of the retail cost of their covered medications and will pay those amounts until they've spent $7,050 in out-of-pocket costs. Based on our previous example, the beneficiary has already satisfied $600 of that cost dur- ing their initial coverage limit, so they would need to spend another $6,450 to move on to the Catastrophic Coverage stage.

During the Coverage Gap, the amount beneficiaries pay for their medications (the 25%) and the discount they're receiving on brand name drugs (70%) will count towards their $7,050 limit.

For example: beneficiary is in the donut hole and has a brand name medication that retails for $100. At the pharmacy county they are only spending $25 out of their pocket, but $95 is going towards the $7,050 limit. On the other hand, their $10 retail cost generic is costing $2.50 at the pharmacy but only $2.50 is going towards the $7,050 limit.

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Catastrophic Coverage

If the beneficiary has reached $7,050 in "out of pocket" costs, they enter the final stage of their plan which is Catastrophic Coverage, and will remain their until the end of the calendar year. During the catastrophic coverage phase, beneficiaries will pay the greater of:

- 5% of the retail drug cost, or
- $3.95 for generic/multi-source brand drugs, and
- $9.85 for all other medications

Formulary

Each Part D plan has a list of covered medications, called a Formulary. This list will include both brand name and generic medications, and must cover at least two options for every therapeutic class of drugs. In order for a beneficiary's plan to cover their prescriptions, they must be included on the plan's specific formulary.

In the event a beneficiary is prescribed a medication that is not on their plan's formulary, they can request a Formulary Exception to have the drug covered under their plan. If there's a medication at a high tier and is unaffordable for the beneficiary, they can request that drug to be moved to a lower tier by requesting a tier reduction. Both of these requests are handled on a case by case basis and any exception/reduction would be for the individual beneficiary only.

Pharmacy Network

Each Part D plan will have its own network of participating pharmacies that plan members must utilize in order to have their prescriptions covered. Some plans utilize a preferred pharmacy network, meaning specific locations in the plan's directory may offer covered prescriptions at a lower copay/coinsurance. Unless it's an emergency situation, prescriptions that are filled at non- network pharmacies will not be covered. Also, plans offer the option to have medications delivered through a mail order pharmacy

Extra Help

Extra Help, also known as Low Income Subsidy (LIS), is a benefit provided by Social Security for Medicare beneficiaries with limited income and resources. If they quality, Extra Help will provide financial assistance with their Part D plan, including:

- Monthly premium
- Late enrollment penalties, if applicable
- Annual deductibles, if applicable
- Copays & coinsurances
- Coverage Gap

Beneficiaries should reach out to their local Social Security office for more information and to apply, or can apply online through www.ssa.gov/prescriptionhelp

Sources:

https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment- premiums-and-cost-sharing-in-2021/

https://www.medicare.gov/drug-coverage-part-d

https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d- late-enrollment-penalty

https://www.ssa.gov/benefits/medicare/prescriptionhelp.html

https://q1medicare.com/PartD-The-MedicarePartDOutlookAllYears.php

https://www.cms.gov/files/document/july-29-2021-parts-c-d-announcement.pdf

Identifying Retirement Income Gaps

Did you know?

The average couple retiring at age 65 can expect to spend almost $1,000 in medical costs[1], $500 on food[2] and $1,300 on housing[2] per month.

1 How much to maintain your lifestyle?

Typically, you will need 75-85% of your current gross monthly income to maintain your current lifestyle. You may need more or less, depending on your expense, health care costs and retirement goals.

Gross Annual Income		
Months	÷	12
Percent of gross monthly income needed	X	
Estimated monthly retirement income needed	=	

2 How much guaranteed monthly income?

Social Security		
Pension	+	
Other income	+	
Estimated monthly income from guaranteed sources	=	

3 How much income from your retirement portfolio each year?

Estimated monthly retirement income needed		
Estimated monthly income from guaranteed sources	−	
Estimated monthly income needed from retirement portfolio	=	

Will your retirement portfolio last your lifetime?

It may be best to plan for retirement to last 30 years.

Estimated monthly retirement income needed from your retirement portfolio		
Number of months	X	
Total funds needed from your retirement portfolio	=	

Allocating a portion of your porfolio to a fixed index annuity is one option that could help you fill monthly income gaps. For example, a 63-year-old male client is considering purchasing an annuity using **IncomeShield 10** with a lifetime income benefit rider (LIBR) and starting joint income at age 70*. No matter how much he decides to purchase, he can feel confident knowing he has monthly income options that will last a lifetime.

Annuity Premium Amount	Monthly Lifetime Income Payment
$100K	$591
$250K	$1,479
$500K	$2,957
$750K	$4,436
$1 Million	$5,914

Guarantees are based on the financial strength and claims paying ability of American Equity and are not guaranteed by any bank or insured by the FDIC. Annuity Contract and Riders issued under from series ICC17 BASE-IDX-B, ICC17 IDX-11-10, ICC20 R-LIBR-FSP, ICC20 R-LIBR-W-FSP, and state variations thereof. Availability may vary by state.

**LIBR available for ages 50+. Hypothetical example includes the following assumptions: an Income Account Value (IAV) rate of 7.25% simple interest; a 7% bonus on first year premium; a joint anniversary as long as the rider is attached to the contract. See disclosure and sales brochure for details.*

[1]Money, "Here's how much the average couple will spend on health care costs in retirement." April, 2018

[2]Bureau of Labor and Statistics. Based on responses from 2017 nationwide survey "Consumer Expenditures Survey." 2018

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Part D Extra Help

The Medicare Part D program started January 1st, 2006, and now covers over 48 million beneficiaries. Part D was the first time the national healthcare program provided prescription drug benefits and helped make medications more affordable. Even with the new savings, many beneficiaries have trouble with the cost of their prescriptions. Part of the Medicare Modernization Act of 2003, the law responsible for Part D, included the Low Income Subsidy program to provide financial assistance to beneficiaries with limited income and resources. This presentation describes the LIS/Extra Help program to give beneficiaries an idea of the benefits and the parameters in which they would qualify.

What is Extra Help?

The Extra Help program is a national program, administered by the Social Security Administration, for Medicare beneficiaries to provide financial assistance in paying the costs of their Part D coverage, including monthly premiums, annual deductibles, and copayments.

Qualifications

In order to qualify, beneficiaries must:

- Medicare Part A and/or Part B
- Have limited income and resources
- Reside in one of the 50 states or the District of Columbia

Individuals that qualify for Extra Help must have Medicare prescription drug coverage in order to utilize the benefits, either through a stand-alone Part D plan (PDP) or a Medicare Advantage Part D Plan (MAPD). NOTE: If a beneficiary qualifies for Extra Help but does not sign up for a Part D or MAPD plan, SSA will auto-enroll them into an available PDP plan.

Resource Limits

SSA utilizes a resources test to determine who qualifies for the benefit. In 2022, resources must be limited to $14,790 for an individual or $29,520 for a married couple living together. An additional $1,500 for an individual and $3,000 for a married couple living together is added to these numbers for money saved for burial expenses.

Resources include the value of the things the beneficiary owns, including real estate (other than their primary residence), bank accounts, stocks & mutual funds, bonds (including U.S. Savings Bonds), individual retirement accounts (IRAs), and cash at home or anywhere else.

What is not counted as a resource are:

- Their primary residence
- Their personal possessions
- Their vehicle(s)
- Resources they couldn't easily convert to cash, such as jewelry or home furnishings
- Property they need for self-support, such as rental property or land they use to grow produce for home consumption
- Non-business property essential to their self-support
- Life insurance policies
- Burial expenses (up to $1,500 for an individual or $3,000 for a married couple living together)
- Interest earned on money they plan to use for burial expenses

There are certain other moneys they hold that's not counted as a resource for nine months from the time of enrollment, such as:

- Retroactive Social Security or Supplemental Security Income (SSI) payments
- Housing assistance
- Tax advances and refunds related to earned income tax credits and child tax credits
- Restitution as a crime victim
- Relocation assistance from a state or local government

Income Limits

Beneficiaries with an annual income of less than $19,320 as an individual and $26,130 as a married couple living together may qualify for Extra Help. Income should be based on what they file for taxes each year, but does not include:

- Supplemental Nutrition Assistance Program (food stamps)
- Housing assistance
- Home energy assistance
- Medical treatment and drugs
- Disaster assistance
- Earned income tax credit payments
- Assistance from others to pay your household expenses, including any benefits they may receive through their Medicare Advantage plan like a monthly OTC allowance, food card, etc.
- Restitution payments
- Scholarships and education grants

Extra Help Benefits

According to the Social Security Administration, Extra Help is estimated to be worth about $5,000 per year per eligible beneficiary. Extra Help provides financial assistance for paying many aspects of Part D coverage, including monthly premiums, late enrollment penalties, annual deductibles (if any), prescription copayments and coinsurances, and the coverage gap.

Premium Subsidy

Based on the beneficiary's income and resources, Extra Help can provide a subsidy to help re- duce or eliminate the plan premium:

Individual Resources	Individual Income	Amount of Premium Subsidy
$7,970 or less	At or below $17,388	100%
$7,970.01 to $13,290	At or below $17,388	100%
$13,290 or less	More than $17,388 to $18,032	75%
$13,290 or less	More than $18,032 to $18,676	50%
$13,290 or less	More than $18,676 to $19,320	25%

Married Resources	Married Income	Amount of Premium Subsidy
$11,960 or less	At or below $23,517	100%
$11,960.01 to $26,520	At or below $23,517	100%
$26,520 or less	$23,517 to $24,388	75%
$26,520 or less	$24,388 to $25,259	50%
$26,520 or less	$25,259 to $26,130	25%

The premium subsidy is based on the "benchmark premium" from CMS. Each Part D region has a specific benchmark premium that it will pay based on the beneficiary's premium subsidy. Here are the 2022 Part D Premium Benchmarks by region:

States	2022 Benchmark	States	2022 Benchmark	States	2022 Benchmark
NH, ME	$30.53	**CT, MA, RI, VT**	$36.27	**NY**	$42.43
NJ	$37.07	**DE, DC, MD**	$36.96	**PA, WV**	$40.74
VA	$35.11	**NC**	$35.82	**SC**	$31.12
GA	32.38	**FL**	$34.32	**AL, TN**	$32.72
MI	$31.49	**OH**	$33.54	**IN, KY**	$29.65
WI	$42.29	**IL**	$29.05	**MO**	$33.42
AR	$26.72	**MS**	$29.22	**LA**	$36.35
TX	$25.10	**OK**	$30.90	**KS**	$32.92
IA, MN, MT, ND, NE, SD, WY	$38.88	**NM**	$34.31	**CO**	$39.81
AZ	$40.04	**NV**	$31.68	**OR, WA**	$40.48
ID. UT	$42.93	**CA**	$33.16	**HI**	$35.98
AK	$32.63				

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For example:

- A 100% premium subsidy in New York will pay up to $42.43 per month in 2022. If the plan costs $50 per month, the beneficiary would pay the difference, a total of $7.57.

NOTE: for MAPD plans that carry a premium, a portion of that premium is for the Part D benefits. As long as the Part D portion of the MAPD premium is not over the benchmark, and the beneficiary qualifies for 100% premium subsidy, then the Part D portion will be covered in full. For example, a MAPD plan has a $25 monthly premium, but the Part D portion is only $10. With a 100% premium subsidy, the client would be left to pay the remaining $15 per month for the health portion of the MAPD premium.

Late Enrollment Penalties

Beneficiaries that qualify for any level of Extra Help, and owe a late enrollment penalty, will have the penalty waived for as long as remain eligible for Extra Help. The penalty is waived regardless of their level of premium subsidy.

Deductible Help

Based on income and resource levels, they may qualify for 100% deductible coverage, or have it reduced to a maximum of $99

	Income Limit	Resource Limit	Deductible
Individual	Up to $17,388	Up to $7,970	$0
Individual	Up to $19,320	Up to $13,290	$99 maximum
Married	Up to $23,517	Up to $11,960	$0
Married	Up to $26,130	Up to $26,520	$99 maximum

Prescription Cost Help

Outside of premiums and deductibles, the main purpose of the Extra Help program is to reduce the cost of medications for the eligible beneficiaries. Depending on their level of income and resources, and their Medicaid status, they could pay as little as $0 for covered medications, or:

Generic/Preferred Multi-Source Copay	Other Drug Copay
$1.35	$4.00
$3.95	$9.85
15%	15%

Their copays would remain the same through the coverage gap, if applicable.

Signing Up for Extra Help

There are three main methods to sign up, either through their local Social Security office, by calling SSA at 800-772-1213, or by going online to ssa.gov/prescriptionhelp (fastest method). The process can take up to 30 days for approval, and beneficiaries should be prepared to provide financial information including all sources of income, checking & savings, stocks, bonds, mutual funds, etc.

Signing Up for Medicare

Getting Started

The first thing to consider when enrolling in Medicare is whether or not you will be automatically enrolled. Individuals that are already collecting their Social Security income payments and have worked their 40 quarters to qualify for premium-free Part A, will automatically be enrolled starting the month they turn 65.

If the beneficiary has not yet elected to receive their Social Security payments, they will be required to sign up for their Medicare Part A and Part B benefits. This can be done during the Initial Enrollment Period (IEP), General Enrollment Period (GEP), or Special Enrollment Period (SEP), if applicable.

When to Sign Up

The Initial Enrollment Period is the first opportunity for a beneficiary to sign up for benefits. It begins 3 months before the month they turn 65, includes the month the turn 65, and three months after the month they turn 65.

Depending on when they sign up during this 7-month period will determine when their benefits go into effect. Best advice, sign up prior to the month they turn 65 to avoid any delays. Here is the chart that Social Security and Medicare use to determine when benefits begin for those that sign up during the IEP:

If you sign up for Part A and/or Part B in this month:	Your coverage starts:
Within 3 months before you turn 65	The months you turn 65
The month you turn 65	1 month after you sign up
1 months after you turn 65	2 months after you sign up
2 months after you turn 65	3 months after you sign up
3 months after you turn 65	3 months after you sign up

This is important to understand, especially those who are trying to align the date they are retiring or losing group employment, as their desired Medicare start date may not be feasible based on the chart.

If an individual does not enroll during their IEP, they can sign up during the General Enrollment Period. The GEP happens every year, from January 1st through March 31st, with any coverage applied for starting on July 1st of that year.

Late Enrollment Penalty

If beneficiaries do not sign up during their IEP, they may be subject to a Late Enrollment Penalty (LEP). The LEP equals 10% for each 12-month period they could have had Part B, and is paid for as long they are active with Part B. Also, the penalty is based on the current Part B premium, so when the Part B premium changes so will the LEP.

Special Enrollment Period

As the last option to enroll in Medicare, there exists a Special Election Period (SEP) for individuals who were covered under employer or union coverage based on their or their spouse's current employment. In other words, the client or their spouse needs to be actively employed and working and covered by employer coverage to use the SEP. They can apply any time they are working and covered under group/union coverage, and up to 8 months after (whichever happens first):

- The month after employment ends
- The month after group/union health insurance ends based on that employment Even if they elect to take their COBRA coverage, which can run for 18 months after loss of coverage, they are still limited to only 8 months after loss of employment/group coverage.

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Delaying Enrollment

If your clients are working and covered under employer coverage, they may choose to delay enrolling in Medicare Parts A and/or Part B depending on the size of their employer. The number of employees as it relates to delaying Medicare is based on the TEFRA law passed in 1982, and are:

- If the employer has fewer than 20 employees:
  - They should sign up for Part A and Part B when they're first eligible
  - If they don't enroll, they may be subject to the LEP
- If the employer has 20 employees or more:
  - They should ask their benefits manager whether they have group health coverage as defined by the IRS, and if so:
  - They can delay enrolling in Medicare when they're first eligible, as their group is considered primary insurance coverage.

How to: Delay Enrollment

If the beneficiary is already receiving Social Security payments, they will receive their Medicare information 3 months prior to the month they turn 65 and their Medicare card shortly thereafter. Once they receive their card, they should fill out the included form indicating that they would like to delay their Part A and/or Part B benefits and mail it back with the card.

If the beneficiary is not already collecting their Social Security payments, they would simply skip the enrollment process and either sign up during the General Enrollment Period or the Special Enrollment Period.

Delaying Enrollment - How to Sign Up

After delaying their Medicare enrollment, they will need to complete two forms in order to sign up for their benefits:

- CMS-40B: *Application for Enrollment in Medicare*, and
- CMS-L564: *Request for Employment Information*

The employer will need to complete the 2nd section on form L564 and sign, this is to certify that the client was covered under group insurance based on active employment for the purpose of avoiding the Late Enrollment Penalty. Once completed, both forms need to be submitted to Social Security.

Delaying Enrollment - Start Dates

Applying for Medicare after delaying enrollment has a big impact on when Part A and Part B benefits will take effect.

Part A will be backdated 6 months from the date they sign up, but not earlier than their 65th birthday month. It's important to note, if they are contributing to a Health Savings Account, they will need to stop their contributions 6 months prior to signing up for Part A or they could be penalized by the IRS.

If the beneficiary signs up for Part B while they are still working, or during the first full month they no longer have group coverage, they can choose to have the first of the month in which they sign up as their effective date, or the first of any of the following 3 months. If they sign up during any of the remaining 7 months of their SEP, the coverage will start the 1st of the month after they sign up.

IEP vs. SEP

Sometimes, a beneficiary may find themselves in a situation where they are applying for coverage during their 7-month IEP, but are also eligible for their SEP due to group insurance. In this situation, the IEP will trump the SEP and Social Security & Medicare will follow the IEP chart to determine effective dates. If a client is going to be retiring any time during their IEP, it's important that they sign up for their Medicare benefits at the right time, or they could run into issues of non-coverage.

Sources:

https://www.medicare.gov/sign-up-change-plans/get-started-with-medicare

https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up- periods

https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/when-will-my-coverage-start

https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/should-i-get-parts-a-b

The Annual Election Period

The Annual Enrollment Period (AEP)

For Medicare Advantage and Part D plans, there are specific times of the year when Medicare beneficiaries can sign up or make changes to their coverage, they are:

- Initial Enrollment Period (IEP) - this happens when a beneficiary turns 65 or first becomes eligible for Part A and/or Part B. It begins 3 months prior to the 65th birthday month, includes the month they turn 65, and ends 3 months after their 65th birthday month.
- Special Enrollment Periods (SEP) - these are specific situations in which a Medicare beneficiary may sign up for or change their Medicare Advantage or Part D coverage. These include loss of group coverage, moving out of their current plan's service area, qualifying for Medicaid and/or Low Income Subsidy, moving into a nursing home, etc.
- Annual Enrollment Period (AEP) - this is open for all Medicare beneficiaries to sign up for or make changes to their Medicare Advantage or Part D coverage.

The AEP starts on October 15th and runs through December 7th.

What Can You Do?

Medicare beneficiaries can make any of the following changes during the AEP:

- Move from Original Medicare Parts A & B to a Medicare Advantage plan (with our without drug coverage)
- Move from a Medicare Advantage plan (with or without drug coverage) to another Medicare Advantage plan (with our without drug coverage)
- Leave their Medicare Advantage (with or without drug coverage) and go back to Original Medicare Parts A & B (with or without drug coverage)
- Join a Prescription Drug Plan (Part D)
- Move from a Prescription Drug Plan (Part D) to another Prescription Drug Plan (Part D)
- Leave a Prescription Drug Plan (Part D) all together

Important Dates

Starting October 1st each year, Medicare Advantage and Part D plan sponsors can release their new benefit information for the following year.

Any changes that are made during the AEP do not take effect until the following January 1st.

Last Application Wins—the last application that is signed and submitted by a Medicare beneficiary is the coverage that will start on January 1st, regardless if they signed up for other coverage prior to and during the AEP. For example, if a client submitted an application for Plan A on October 15th, but then sign up for Plan B on November 20th, Plan B will go into effect January 1st. There is no need for the client (or the agent) to call and cancel their other application as long as it was for a Medicare Advantage or Part D plan. If they signed up for a Medicare Supplement plan, they will need to notify the carrier of their intent to withdraw their application.

Annual Notice of Change (ANOC)

Medicare Advantage and Part D plan sponsors (carriers) are required to notify their beneficiaries of year-to-year changes by sending them an Annual Notice of Change. The ANOC letter is to be received by October 1st each year and will provide information about updates to their plan, in- cluding a side-by-side comparison of their benefits year-over-year. NOTE: Agents are not allowed to discuss new plan information with current beneficiaries until this notice is received, or after October 1st each year (whichever happens first).

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The AEP Checklist

The AEP checklist is a simple plan that Medicare beneficiaries should follow each AEP to ensure they are in the best-fit Medicare Advantage or Part D plan for the following year, since opportunities to change are limited by available enrollment periods.

#1 - Review changes in current coverage. Utilizing the ANOC letter, beneficiaries should review changes to their current coverage including copays, drug costs, covered medications, provider networks and pharmacy networks. Plus, it's a good to time to see if there have been any additional benefits added or removed from their plans.

#2 - Quote prescription drugs. Drug costs and coverage change on an annual basis. Medicare beneficiaries are encouraged to quote their drug cost against the new plans starting October 1st to see if there may be changes to their expected out-of-pocket costs for the following year.

#3 - Evaluate Healthcare Needs. The AEP is the right time for Medicare beneficiaries to reflect on the year to determine if their current coverage was adequate. They should consider if their expected utilization was as expected, above expectations or below expectations. They should also consider if they've been diagnosed with a new conditions, are taking new medications, are seeing new providers or if anything was missing from their healthcare coverage.

#4 - Make a change, or stay put. After steps #1-3, if beneficiaries are satisfied with their coverage they can continue on the same plan for the following year, but if they find need to make a change they must submit an application by December 7th to start their new coverage January 1st of the following year.

What's Next?

From December 8th to the 31st, Medicare beneficiaries who made a change can expect to receive their new ID cards and plan information in the mail. It's important for them to review their new coverage to verify it's the program they signed up for and to prepare for their first doctor/ pharmacy visit in the new year once coverage takes effect.

For Medicare Advantage and Part D beneficiaries that did not make a change during AEP, they should have received their new ID cards and plan information in the mail.

Open Enrollment Period

Starting January 1st and running through the entire month of March, there exists the Medicare Advantage Open Enrollment Period (OEP). Strictly for Medicare Advantage beneficiaries, this is an opportunity to make a change to their current plan should the need arise (i.e. benefits/ coverage issues, provider network issues, etc.) They have a one-time opportunity to make either of the following changes:

- Switch from one Medicare Advantage plan (with or without drug coverage) to another Medicare Advantage plan (with or without drug coverage)
- Leave their Medicare Advantage plan (with or without drug coverage) to go back to Original Medicare Parts A & B. They'll also be able to join a Part D plan.


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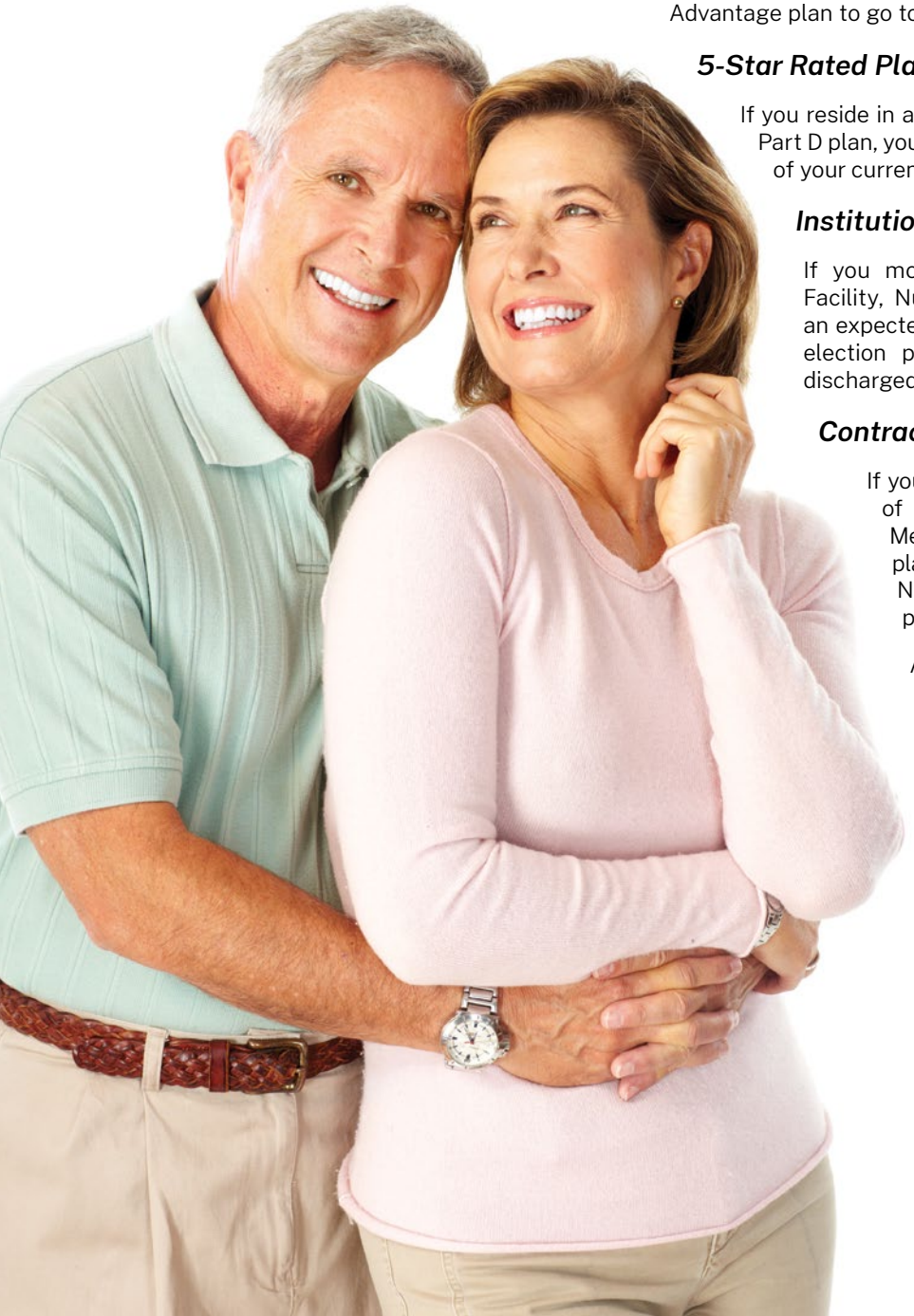
Special Election Periods

In order to enroll into, change, or terminate a Medicare Advantage or Part D plan, you must have a valid Election Period. Election Periods are based on specific triggers - they can happen certain times of the year, when you're receiving Medicare for the first time, or under other special circumstances throughout the year. Here are some of the most common Special Election Periods you should know about.



Loss of Employer Coverage

If you're on Medicare and lose your complyer group, union, retiree or COBRA coverage, you can sign up for a Medicare Advantage or Part D plan up to 3 months in advance, and up to 2 months after your coverage ends.

Change in Residence

If you move out of your plan's current service area, or into a new service area with new plan options, you have up to 2 months after the move to sign up for or change your Medicare Advantage or Part D coverage.

Dual/Extra Help Eligible

If you qualify for Medicaid or the Part D Extra Help program, you have a continuous enrollment period you can use once per quarter for the first three quarters of the year to sign up, change plans, or leave your Medicare Advantage plan to go to a stand-alone Part D plan.

5-Star Rated Plans

If you reside in an area with a 5-star rated Medicare Advantage or Part D plan, you can join that plan any time of the year, regardless of your current coverage.

Institutionalized

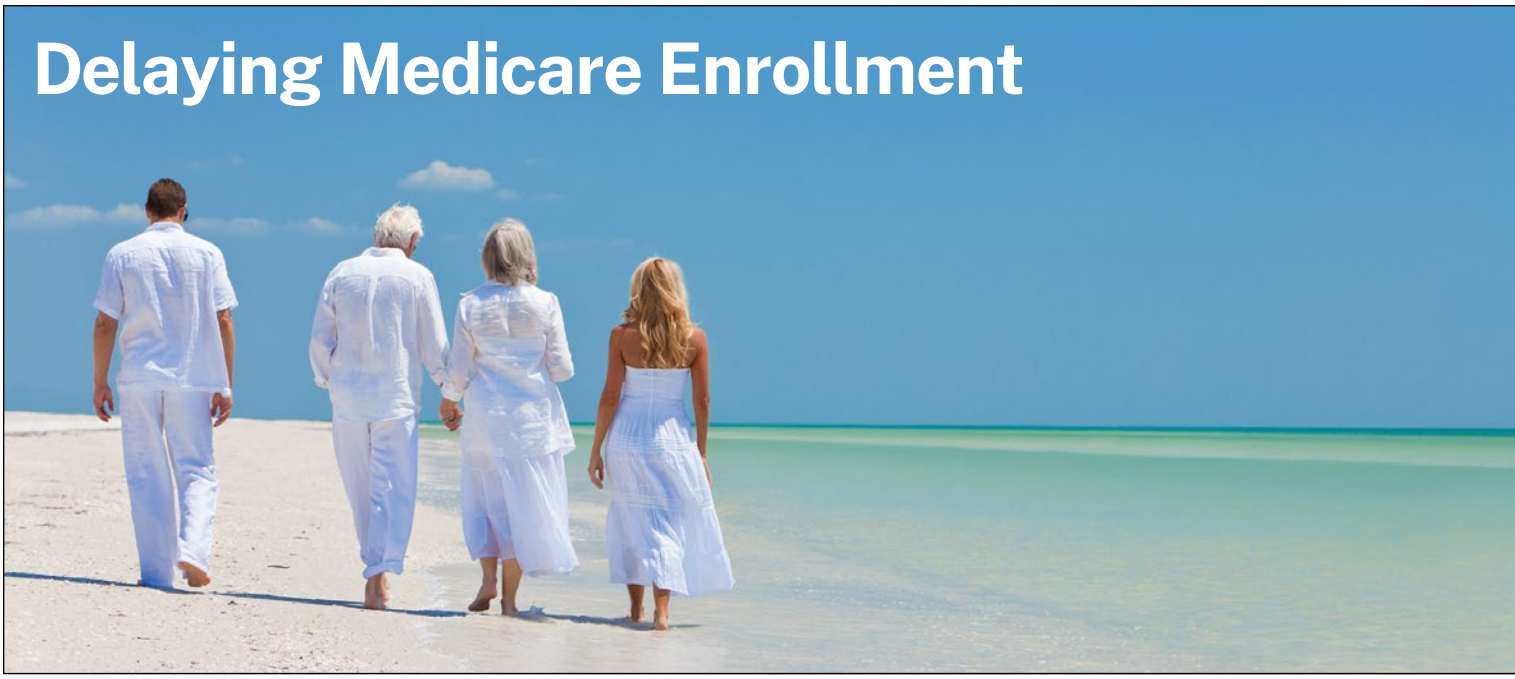
If you move into, reside in, or leave a Skilled Nursing Facility, Nursing Facility, or intermediate care facility with an expected stay of at least 90 days, you have a continuous election period that lasts up to 2 months after you're discharged.

Contract Non-Renewal

If your Medicare Advantage plan is leaving your county of residence next year, you can sign up for a new Medicare Advantage Plan or stand-alone Part D plan from December 8th through February 28th. NOTE: you may also have a guarantee issue right to purchase a Medicare Supplement plan.

Any time you have a change in residence, your current coverage, or your financial situation there may be a Special Election Period you can use!

Delaying Medicare Enrollment



There are many reasons why someone would delay enrolling into Medicare, but that can have big impacts on accessing benefits later in life. This presentation is designed to briefly cover some of the reasons for delaying enrollment, but focuses heavily on how to enroll when the time comes.

Why Delay Medicare?

- Still working and have group coverage. This is for individuals that are covered under employer or union group coverage based on their or their spouse's current employment
- Currently contributing to a Health Savings Account. These individuals will also have a HDHP plan through their employer or union and are actively working, but there are implications on enrolling into Medicare Part A and B which we'll discuss later.
- Do not qualify for premium-free Part A. The monthly cost for Part A, if you have to pay a premium, ranges from $471-$259 per month for 2021.
- Utilize VA for all health services. Many of these individuals delay enrolling in Part B and are shocked to learn of the late enrollment penalty when they go to sign up in the future.
- Have insurance from the Health Insurance Marketplace. If you have a marketplace plan and then qualify for Medicare, you can keep the marketplace plan but are no longer eligible to receive any premium tax credits, so some choose to delay their Medicare to keep the plan. Unfortunately, marketplace plans are not creditable for delaying coverage and those individuals could pay a penalty in the future.

How To: Delay Part A

In order to delay Part A, the beneficiary needs to understand if they are already receiving, or will be getting, their benefits from Social Security or the Railroad Retirement Board (RRB). If they are receiving those benefits, there is no way to delay their Part A coverage. If they are not yet receiving those benefits then they can delay their Part A coverage by simply no signing up.

How To: Delay Part B

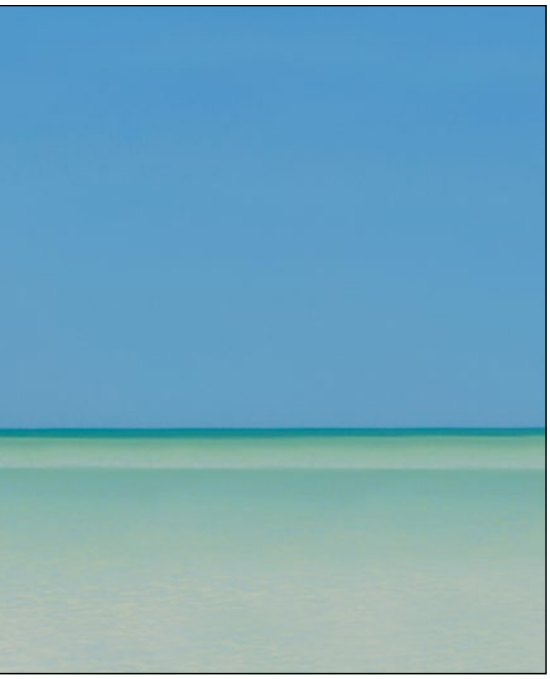
There are numerous ways to delay Part B coverage, but depending on their SSI/RRB status will change what needs to be done as they approach age 65

Will be getting SSI/RRB benefits at least 4 months before they turn 65:

- Follow the instructions that come with their Medicare card to decline Part B coverage and send it back, or:
- Contact Social Security at 800-772-1213 to delay coverage.

Will not be getting SSI/RRB benefits at least 4 months before they turn 65:

- Simply do not sign up for Part B benefits.



Signing Up for Benefits

After delaying Medicare A and/or B, there are different ways to sign up for benefits depending on the beneficiary's specific situation.

Part A

If your client is eligible for premium-free Part A, they can enroll at any time after they're first eligible for Medicare with no late enrollment penalty - all they have to do is contact Social Security to enroll.

However, their Part A will go into effect retroactively 6 months from when they first signed up, but no earlier than the first month they were eligible for Medicare. For individuals that are con- tributing to a HSA this is very important, as they will need to stop contributing to their account 6 months prior to signing up.

If your client is not eligible for premium-free Part A:

- There is a 10% penalty for every 12-month period they were eligible but did not have Part A
- The penalty will be paid for twice the number of years they went without cover (i.e. if they went 2 years without coverage, they would pay the Part A penalty for 4 years)
- They must sign up for Part B (or be actively enrolled) in order to buy Part A, and will be subject to signing up during a valid timeframe (SEP/GEP)

Part B

- Apply online with Social Security at https://ssa.gov/benefits/medicare
- Visit your local Social Security office or call them at 800-772-1213
- If your client worked for a railroad, have them call the RRB at 877-772-5772 to sign up
- If they already have Part A and want to sign up for Part B, they will need to complete the CMS- 40B form (and CMS-L564 form if they were working)

Part B Sign Up Periods

Initial Enrollment Period - 3 months before, the month of, and 3 months after their 65th birthday month. Their benefits start date is determined by when they enrolled during their IEP:

If you sign up for Part B in this month:	Your coverage starts:
3 months prior to your 65th birthday month	The 1st of the month you turn 65
The month you turn 65	1 month after you sign up
1 month after you turn 65	2 months after you sign up
2 months after you turn 65	3 months after you sign up
3 months after you turn 65	3 months after you sign up

Special Enrollment Period - this only applies to individuals who were covered under employer or union coverage based on their or their spouse's current employment. They can sign up any time they are covered by the plan, or up to 8 months after their coverage or employment ends, whichever happens first.

General Enrollment Period - this happens between January 1st to March 31st each year, with coverage starting the following July 1st.

Part B Late Enrollment Penalty

If your client delayed Part B, they may have to pay a Late Enrollment Penalty (LEP) when they sign up.

- 10% for every 12-month period since they were eligible
- Penalty is waived if they qualified for the Part B SEP and signed up during that timeframe
- Retiree plans, individual health, ACA and Veterans Benefits are not creditable coverage for delaying part B

Recap

There's a great resource that's published by CMS called *CMS Fact Sheet: Deciding Whether to Enroll in Medicare Part A and Part B When You Turn 65* (CMS Publication No. 11962). This document has a great "choose-your-own-story" flow to it that will help you quickly identify your client's specific satiation and how they should approach the idea of delaying their Medicare benefits. You should help every client determine when they should apply for benefits to make sure that no opportunities are missed, and that they can avoid any late enrollment penalties.

Sources:

https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/FS3-Enroll-in-Part-A-and-B.pdf

https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/should-i-get-parts-a-b https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/when-will-my-coverage-start

Late Enrollment Penalties

There are situations where Medicare beneficiaries may have to pay more for their Medicare coverage because they delayed enrolling when they were first eligible. This article is designed to help beneficiaries identify when they may be at risk of paying a Late Enrollment Penalty (LEP) and how they can avoid it.

What are they?

If beneficiaries don't sign up for certain parts of Medicare when first eligible, their monthly premi- ums may go up due to a Late Enrollment Penalty. There are three LEPs to be aware of:

- Part A - Hospital Insurance
- Part B - Outpatient Insurance
- Part D - Prescription Drug Insurance

Part B Late Enrollment Period

If Medicare beneficiaries don't sign up for Part B when they're first eligible, their monthly premi- um may go up 10% for each 12-month period they could've had Part B, but didn't sign up. In most cases, they'll have to pay the LEP each time they pay their premiums, for as long as they have Part B coverage.

Example: Their Initial Enrollment Period (3 months before, the month of their 65th birthday, three months after) ended December 2016, and they signed up in March of 2019 during the General Enrollment Period. Their Part B starts on July 1, 2019, leaving a gap of 31 months in which they were eligible for coverage but didn't have it. The penalty is only applied when they experience a full 12-month period without coverage:

31 / 12 = 2.583

Since there are only two full 12-month periods without coverage, their Part B LEP penalty will be 20%. Social Security will collect the penalty through their regular Part B premium payments.

Part B LEP Exceptions

If they were covered by employer or union group coverage based on their or their spouse's cur- rent employment, they can:

- Sign up at any time while they're covered under the plan
- Sign up within 8 months after the loss of coverage or employment, whichever happens first

Signing up during this Special Enrollment Period will avoid having to pay the Part B Late Enrollment Penalty.

Part B LEP Exceptions Continued

If they have limited income and resources, their state may help pay for their Part B premiums through the Medicare Savings Program.

- Monthly Income Limit (2021) - $1,308 individual / $1,762 married
- Resource Limit (2021) - $7,970 individual / $11,960 married (includes stock, bonds, mutual funds, money in checking/savings)

These are the limits for the Specified Low-Income Medicare Beneficiary level of the Medicare Savings Program. These individuals may also qualify for Extra Help to pay for their Medicare Part D coverage.

Part D Late Enrollment Period

Beneficiaries may owe a penalty if at any time after their Initial Enrollment Period (3 months before, the month their Part A and/or B benefits start, 3 months after) ends, there's a period of 63 consecutive days or more when they didn't have creditable drug coverage. They'll generally have to pay the penalty for as long as they have Medicare Part D coverage (including Part D coverage built into a Medicare Advantage plan).

The cost of the penalty depends on how long they went without Part D or creditable drug coverage before signing up. The formula is:

1% of the national base premium times the number of full months they didn't have Part D or creditable coverage, then rounded to the nearest $.10 and added to their monthly Part D premium.

As the national base premium changes each year ($33.06 in 2021) so will the Part D LEP.

Example: Their IEP ended May 31, 2017, and signed up for Part D beginning January 1, 2020. Since they were without coverage for 31 months, their penalty is $10.30 each month in 2021.

$33.06 (base premium) X .31 (1% x 31 months) = $10.25, rounded to the nearest $10 = $10.30

Part D (or MAPD) carriers are responsible for notifying the beneficiary of the late enrollment penalty and collecting the premium on a monthly basis. Even if the beneficiary has a $0 premium Medicare Advantage plan, they will receive a bill from their MA carrier for the cost of the Part D LEP

Part D LEP Exceptions

If beneficiaries had creditable coverage since their IEP ended, they will not be charged a penalty when they sign up for Part D coverage. Examples of creditable coverage include:

- Employer/Union Coverage
- State Pharmaceutical Assistance Programs
- Indian Health Service
- VA
- TRICARE/TRICARE for Life
- Individual Health Insurance Coverage

Beneficiaries with limited income and resource may qualify for Extra Help on their Part D coverage.

- Income less than 150% of the Federal Poverty Level, and
- Resources less than $13,920 individual / $26,520 married (2021 limits). Resources include stock, bonds, mutual funds, real estate other them primary residence, more then one car, money in a check or savings account, and more.

As long as the beneficiary qualifies for Extra Help, they will not owe a Late Enrollment Penalty.

Part A Late Enrollment Penalty

If a beneficiary doesn't quality for premium-free Part A (worked 40 quarters paying taxes or claiming under an eligible spouse), and they don't buy Part A when their first eligible, their monthly Part A premium may go up 10%. This penalty is owed for twice the number of years they didn't sign up.

Example: The beneficiary was eligible for Part A for 5 years but didn't sign up and have now purchased coverage. They'll have to pay the 10% penalty for 10 years.

Part A LEP Exceptions

If they were covered by employer group coverage based on their or their spouse's current employment, they can:

- Sign up at any time while they are covered under the plan, or
- Sign up with in 8 months after the loss of coverage or employment, whichever happens first Signing up during this Special Enrollment Period will eliminate any Part A LEP charges.

Also, if they have limited income and resource, their state may help them pay for their Part A premiums through the Medicare Savings Program:

- Monthly Income Limit (2021) - $1,094 individual / $1,472 married
- Resource Limit (2021) - $7,970 individual / $11,960 married

These limits are for the Qualified Medicare Beneficiary level of the Medicare Savings Program, or may be referred to as Full Benefit Dual Eligible. Beneficiaries at the Specified Low-Income Medicare Beneficiary (SLMB) level do not qualify for Part A premium assistance.

Appeals

Beneficiaries who believe they are wrongly being charged a Late Enrollment Penalty can file an appeal to overturn the decision.

Medicare Part A and Part B

Appeals should be filed with Social Security either by calling them at 800-772-1213, or visiting a local office.

For Medicare Part D appeals, they should reach out to their current Part D carrier for assistance.

Sources

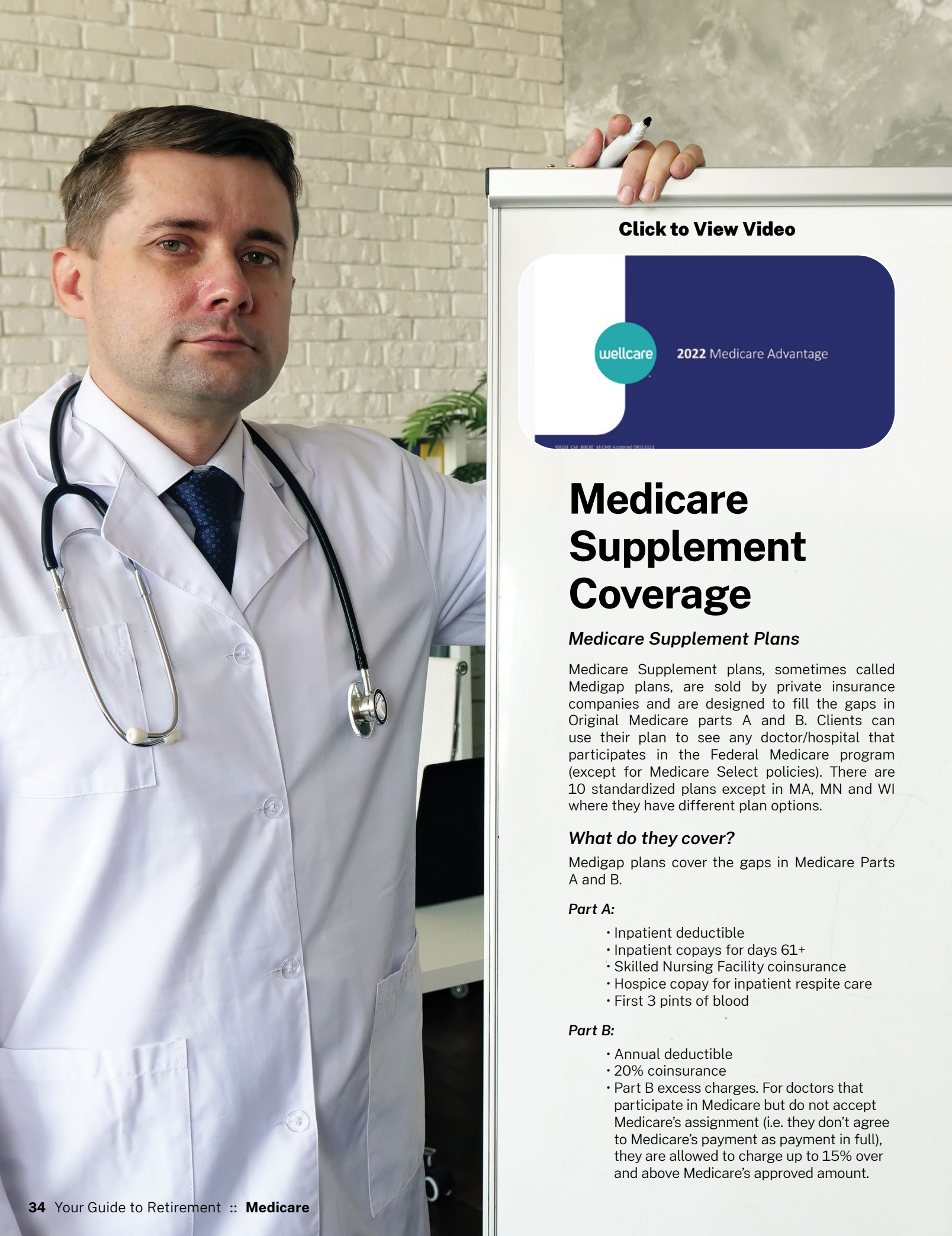
https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-late-enrollment-penalty

https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d- late-enrollment-penalty

https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/find-your-level-of-extra-help-part-d

https://www.medicare.gov/your-medicare-costs/part-a-costs/part-a-late-enrollment-penalty

https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings- programs



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Medicare Supplement Coverage

Medicare Supplement Plans

Medicare Supplement plans, sometimes called Medigap plans, are sold by private insurance companies and are designed to fill the gaps in Original Medicare parts A and B. Clients can use their plan to see any doctor/hospital that participates in the Federal Medicare program (except for Medicare Select policies). There are 10 standardized plans except in MA, MN and WI where they have different plan options.

What do they cover?

Medigap plans cover the gaps in Medicare Parts A and B.

Part A:

- Inpatient deductible
- Inpatient copays for days 61+
- Skilled Nursing Facility coinsurance
- Hospice copay for inpatient respite care
- First 3 pints of blood

Part B:

- Annual deductible
- 20% coinsurance
- Part B excess charges. For doctors that participate in Medicare but do not accept Medicare's assignment (i.e. they don't agree to Medicare's payment as payment in full), they are allowed to charge up to 15% over and above Medicare's approved amount.

Medigap plans can also cover travel to a foreign country, additional home health care days and preventive services not covered by Medicare.

National Options

In all states except MA, MN and WI, there are 10 modernized plans that carriers can make available to beneficiaries: A, B, C, D, F, G, K, L, M, N.

Benefits	Medicare Supplement Insurance (Medigap) Plans									
	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)	x	x	x	x	x	x	x	x	x	x
Medicare Part B coinsurance or co-payment	x	x	x	x	x	x	50%	75%	x	x**
Blood (first 3 pints)	x	x	x	x	x	x	50%	75%	x	x
Part A Hospice care coinsurance or copayment	x	x	x	x	x	x	50%	75%	x	x
Skilled nursing facility care coinsurance			x	x	x	x	50%	75%	x	x
Part A deductible		x	x	x	x	x	50%	75%	50%	x
Part B deductible			x		x					
Part B Excess Charges					x	x				
Foreign Travel Emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-Pocket Limit 2022			
							$6,200	$3,310		

The most commonly sold plans are F and G, as they provide two of the most comprehensive benefit packages available. The biggest difference between the plans are the coverage for the Part B deductible, with Plan G leaving out that coverage. As of January 1st, 2020, individuals who qualify for Medicare or turn age 65 after that date cannot purchase a plan that covers the Part B deductible, so Plan G has become the go-to option for many newly-eligible beneficiaries.

You can also find high-deductible options of plans F and G, in which Medicare will pay first, then the client is responsible for 100% of out-of-pocket costs until they reach a yearly deductible, then the supplement plan will pick up 100% of the costs for the remainder of the year. These plans have a premium that is considerably less than traditional F and G options, but availability will vary by state.

Plan N has become a popular option since it was released in 2010, providing a comprehensive package of benefits for an affordable premium. For some Part B services, policyholders may pay up to a $20 for a doctor office visit and up to a $50 copay for emergency room visits (which is waived if they are admitted to the hospital).

Plans K & L offer a cost-sharing option to beneficiaries, as the plans cover either 50% or 75%, respectively, of the gaps in Medicare up to a specific out-of-pocket limit, then 100% thereafter. In most states, plan K is the lowest premium option available to consumers and may be a popular option for individuals who consider themselves healthy and are looking for the protection and freedom of a Medigap plan without the high price of a Plan F or Plan G.

Select Medicare Supplement plans are available in some parts of the country, and mimic the benefits of any of the modernized plans (A thru N), but utilize a specific network of hospitals and, in some cases, doctors that policyholders must use for any planned procedures. These plans are only offered in specific zip codes and if a client moves out of the plan's service area, they would have a guaranteed right to purchase a plan from any carrier.

Medigap Benefits	Medigap Plans		
	Core	Supplement 1*	Supplement 1A
Basic Benefits	Yes	Yes	Yes
Part A: inpatient hospital deductible	No	Yes	Yes
Part A: skilled nursing facility coinsurance	No	Yes	Yes
Part B: deductible	No	Yes	No
Foreign travel emergency	No	Yes	Yes
Inpatient days in mental health hospital	60 days per calendar year	120 days per benefit year	120 days per benefit year
State-mandated benefits*	No	Yes	Yes

Massachusetts

Massachusetts offers three policy options, Core, Supplement/Plan 1 and Supplement/Plan 1A.

Basic benefits include:

- Inpatient hospital coinsurance up to 365 additional days after Medicare coverage ends
- Part B coinsurance
- First 3 pints of blood
- Part A hospital coinsurance or copay

State-mandated benefits include yearly Pap test and mammograms. Supplement/Plan 1 is only available to beneficiaries who turned age 65 or were active on Medicare prior to January 1, 2020.

Continued on Page 36

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Minnesota

Minnesota offers two plans, a Basic plan w/rider and an Extended Basic plan.

Medigap Benefits	Medicap Plans	
	Basic	Extended
Basic Benefits	Yes	Yes
Part A: inpatient hospital deductible	No	Yes
Part A: skilled nursing facility coinsurance	Yes (100 days)	Yes (120 days)
Part B: deductible	No	Yes
Foreign travel emergency	80%	80%
Outpatient mental health	50%	50%
Usual and customary fees	No	80%
Medicare-covered preventative care	Yes	Yes
Physical therapy	20%	20%
Coverage while in a foreign country	No	80%
State-mandated benefits	Yes	Yes

Basic benefits include:

- Part A coinsurance
- Part B coinsurance
- First 3 pints of blood
- Part A hospice and respite care
- Part A and B home health services and supplies.

State mandated benefits include:

- Diabetic equipment and supplies
- Routine cancer screening
- Reconstructive surgery
- Immunizations
- Refer to outline of coverage for more mandated benefits

The Extended basic plan cannot be sold to beneficiaries who turned 65 or become eligible for Medicare after January 1st, 2020, so they can purchase the Basic plan and add any available riders, including:

- Part A Deductible
- Part B Deductible (for those on Medicare/age 65 prior to 1/1/2020)
- Part B Excess Charges
- Preventive Care

Wisconsin

Wisconsin offers a basic plan with optional plan riders.

Basic benefits include:

- Inpatient Part A coinsurance
- Part B coinsurance
- First 3 pints of blood.

The Part B deductible rider only available to those age 65 or on Medicare prior to January 1st, 2020.

The Part B Copayment or Coinsurance rider provides premium savings in exchange for policy- holder paying up to a $20 copay for doctor office visits and up to $50 for emergency room visits (waived if admitted), and cannot be combined with the Part B deductible riders.

Medicare Supplement Benefits	Basic Plan
Basic Benefits	✓
Medicare Part A: Skilled Nursing Facility Coinsurance	✓
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	40 visits in addition to those paid by Medicare
Medicare Part B Coinsurance	✓
Outpatient Mental Health	✓
State-Mandated Benefits	✓

Optional Riders
Insurance companies are allowed to offer these riders to a Medicare supplement policy:
1. Medicare Part A Deductible
2. Medicare 50% Part A Deductible
3. Additional Home Health Care (365 visits including those paid by Medicare)
4. Medicare Part B Deductible
5. Medicare Part B Copayment or Coinsurance
6. Medicare Part B Excess Charges
7. Foreign Travel Emergency

Select plans are also available, meaning that the client would need to utilize in-network hospitals for any and all planned hospital visits.

Wisconsin mandated benefits include 30 days of skilled care in a skilled nursing facility, inpatient & outpatient expenses for kidney dialysis, transplantation, or donor-related services of kidney dis- ease, diabetes treatment, chiropractic care, colorectal cancer screening, and coverage of certain health care costs in cancer clinical trials.

How much do they cost?

Premiums for Medigap policies can vary based on age, gender, zip code, health conditions and tobacco use. As a general rule of thumb, plans with lower benefits will have lower premiums, and plans with higher benefits mean higher premiums. It's best for beneficiaries to get as many quotes as possible so they can understand all their options.

Premiums structures will vary across states, and will either be Attained Age, Issue Age, or Community Rated.

Attained Age

States: AK, AL, CO, DC, DE, HI, IA, IL, IN, KS, KY, LA, MD, MI, MS, MT, NC, ND, NE, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WI, WV, WY

Premiums are based on the current age of a client, and will increase each year as the policyholder ages. Rates can also be adjusted for gender, zip code, health conditions and tobacco use. The premiums can also change when the companies adjust rates for all policyholders, usually once pear year.

Issue Age

States: AZ, FL, GA, ID, MO, NH

Premiums are based on the age of the client when they first purchase the plan. Rates can also be adjusted for gender, zip codes and tobacco use. The premiums can change when the companies adjust rates for all policyholders, usually once per year. Premiums will be their lowest at age 65.

Community Rated

States: AR, CT, ME, MN, NY, VT, WA

Premiums are the same regardless of age or gender, but can vary based on zip code, health conditions and tobacco use. Premiums only change when the companies adjust rates for all policyholders, usually once per year.

When can I buy one?

Open Enrollment Period

The Open Enrollment Period starts when a client turns age 65 or starts their Part B and lasts for 6 months. They can choose any plan from any carrier during this time, and can even change plans from one to the next during the 6-month period. They cannot be denied due to health history but may be subject to tobacco rates (varies by state/carrier).

Guaranteed Issue

These are certain situations where a client has a guaranteed right to buy a policy and their acceptance is guaranteed. These include losing group coverage, moving out of a Medicare advantage plan's service area, your Medicare Advantage plan is leaving your county, you join a Medicare Advantage plan for the first time after leaving a Medicare Supplement plan and decide to change back within 12 months, loss of Medicaid (varies by state), etc. Please refer to the Choosing a Medigap Policy guide for full details.

Underwriting

Medicare Beneficiaries can apply for a Medicare Supplement plan at any time, as long as they can pass underwriting.

- Series of yes/no health questions
- Company may ask for prescription information
- May require a telephone interview

IMPORTANT: Beneficiaries should not cancel their current coverage until they receive approval from the Medicare Supplement carrier.

Under Age 65 Plans

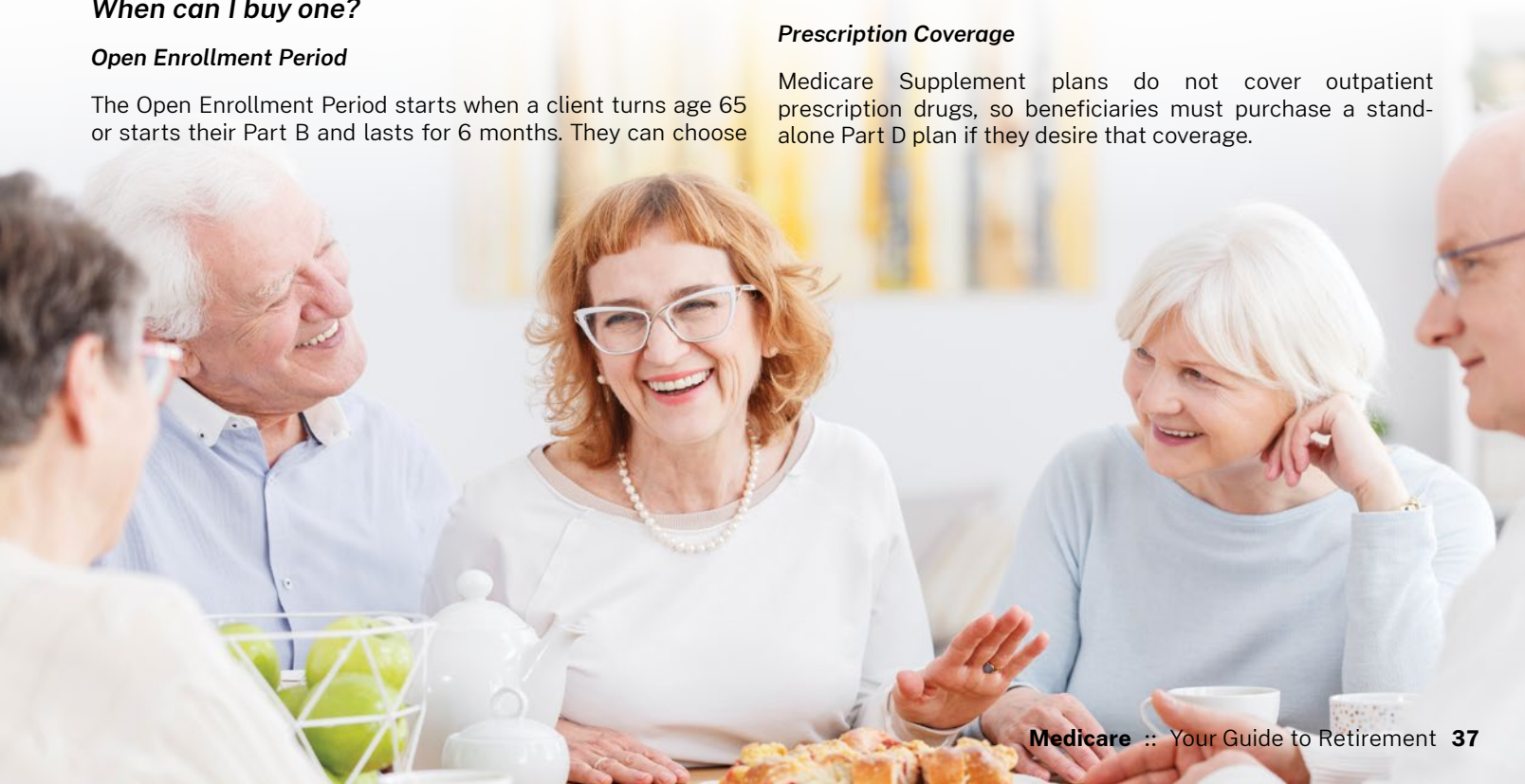
Many states offer plans to individuals who qualify for Medicare due to disability or specified disease under age 65. Available plans may vary and certain time restrictions may apply.

Guaranteed Renewable

All Medicare Supplement plans are guaranteed renewable, which means that insurance carriers cannot cancel a policy for any reason as long as premiums are being paid. This means that beneficiaries cannot be canceled because they move from one state to another or have high claims.

Prescription Coverage

Medicare Supplement plans do not cover outpatient prescription drugs, so beneficiaries must purchase a stand-alone Part D plan if they desire that coverage.



When should you collect Social Security?

While you can start collecting benefits at age 62, should you collect early or delay?

For many elderly people, Social Security benefits make up one of their primary sources of income in retirement. For half of seniors, Social Security comprises about half of their retirement income, according to the Center on Budget and Policy Priorities. Some studies estimate that without Social Security, between 30% and 40% of senior citizens would be considered below the poverty line.

The age at which you decide to collect your Social Security benefits has a big impact on how much you'll earn from the program over time because the longer you wait, the higher your monthly payout will be.

"Don't just call Social Security and apply at age 62. Everybody has options. A married couple could receive $1 to $1.5 million in benefits over their lifetime. And single people could [receive] maybe half of that," says Marc Kiner, a CPA at Premier Social Security Consulting. "And do not assume that Social Security will review your options with you."

Select spoke to Kiner and Jim Blair, the lead consultant at Premier, about some of the factors you should consider when deciding when to apply for Social Security benefits.

The basics of Social Security

First off, every eligible worker can begin receiving Social Security benefits at age 62, but you'll get a reduced monthly payment if you don't wait until you're at full retirement age. Your monthly payment will depend a few things, including your income throughout your working years, how much you paid into the Social Security system and at what age you claim benefits. Benefits are adjusted yearly based on the cost of living.

Full retirement age depends on the year you were born:

- If you were born between 1943 and 1954, full retirement age is 66
- If you were born between 1955 and 1959, full retirement age is between 66 and 67, depending on your birth year
- If you were born after 1960, full retirement age is 67

The Social Security website provides a calculator to help individuals understand how much their benefit will be reduced if they collect early. For example, if you were born in 1960 and wanted to collect as soon as you hit age 62, you'd receive 70% of your full retirement age payout. But if you waited until age 64 you'd get 80% of the full benefit.

By delaying the receipt of your benefits past full retirement age, you'll earn even more than the full benefit — for every year after full retirement age and before you hit age 70, you'll collect 8% more each year.

- If you're full retirement age is 66, you can earn up to 132% of your full benefit by waiting until you're 70 (8% * 4 yrs)
- If you're full retirement age is 67, you can earn up to 124% of your full benefit by waiting until you're 70 (8% * 3 yrs)

What is the break-even point and why is it important?

Whenever you wait until age 70 to collect benefits, you'll be missing out on the years you weren't receiving payments. If you're deciding when to collect, you might consider calculating your break-even point.

Your break-even point tells you at what age you'll receive more in total Social Security earnings, by collecting at full retirement age or at age 70, than you would have had you collected benefits early.

For many people, the breakeven point is around 12 and ½ years after age 70 or full retirement age, says Blair.

For example, if you collected early at age 62 rather than delay until your full retirement age of 67, you would be earning an additional five years worth of benefits. However, if you collected at 62, your benefit would be reduced by 30%. An individual collecting at age 67 would need to survive around another 12 years after collecting benefits to 'break even' compared to getting payouts starting at age 62.

You can calculate your own break even number, but note that the number might not be accurate if you don't consider factors like the cost of living adjustment or having a spouse, divorced spouse or survivor's benefit.

What other factors should you consider when deciding to collect Social Security?

Before you decide to collect Social Security based on your break even point, you should also consider how collecting early or delaying could impact the benefit your spouse receives.

Since the Social Security formula benefit is based on an individual's 35 highest earning years, women often collect less in benefits than men because of career breaks during motherhood and overall lower lifetime earnings. However, the Social Security spousal benefit erases some of the disparity in Social Security earnings between men and women.

The spousal benefit is available to all spouses, regardless of whether the spouse has a work history or not (this also applies to same-sex couples). The spousal benefit is up to 50% of the higher earner's benefit and in order for a spouse to receive the benefit, the higher-earner must be collecting their own benefit.

The Social Security administration automatically determines whether an individual would earn more in Social Security benefits if they collected on their own work record versus their partner's work record.

For example, if the higher earner receives a $2,000 monthly benefit, the spouse is eligible to receive up to $1,000, depending on whether they choose to wait until full retirement age, says Kiner. For example, if someone collects the spousal benefit four years before full retirement age, their benefit will be 35% of the higher-earner's benefits. (Note: If the higher-earner collects their benefit at age 70, the spouse is still only able to collect 50% of the higher-earner's benefit.)

For working individuals who want to collect Social Security benefits early (before full retirement age), having income will have an impact on the amount of money you receive. There's a $19,560 income limit (for 2022,) for working individuals. This means that if you make above $19,560, $1 will be deducted from your yearly Social Security payment for every $2 you make above the annual income limit.

For example, if you make $40,000 and collect Social Security benefits at age 62, the Social Security administration will withhold $10,220 worth of annual Social Security benefits by sending you fewer checks per year. When you reach full retirement age Social Security will recalculate, and typically increase, the value of your benefit (by decreasing the reduction factor they calculated when you were working), so you can recoup some of the earnings you missed out on when you were working, according to Kiner.

Supplementing your Social Security income

For many retirees, the income they receive from Social Security is not enough to live off of: According to AARP, the estimated average Social Security monthly benefit in 2022 is $1,657. If you haven't started saving for retirement it's essential to start early so you can take advantage of the power of compound interest (or interest you earn on interest).

If your company offers an employer-sponsored 401(k) with matching contributions, you should prioritize receiving the match because it's essentially free money.

You might also consider opening an individual retirement account, either a traditional IRA or a Roth IRA, both of which have unique tax benefits.

With a traditional IRA, individuals invest pretax income and don't pay taxes until they withdraw their earnings. With a Roth IRA individuals invest after-tax money so their withdrawals are tax-free. A Roth IRA is considered a good option for those who anticipate being in a higher income tax bracket in retirement: Rather than paying higher taxes later on, you'll pay taxes on your contributions upfront.

A Roth IRA, however, is not available to everyone. For 2022, the income limit for single-filers is $144,000 and for married couples filing jointly it's $204,000. Companies like Vanguard, Wealthfront, Betterment, and Fidelity Investments all provide traditional and Roth IRA options.

If you don't know where to start when it comes to building your retirement portfolio, Wealthfront and Betterment are robo-advisors that use algorithms to determine the right make up of investments for you. Users enter information about their financial goals, investment horizon and risk level and the algorithm will create a custom portfolio to match these needs. In order to meet your goals, robo-advisors automatically rebalance your portfolio over time by buying and selling assets.

Bottom line

It's important to understand how collecting at different ages can influence how much money you'll receive from Social Security. You should consider how collecting early or delaying your benefits impacts how much your spouse receives too.

There are plenty of different factors you need to account for when determining when to collect your benefits, but doing so could mean earning thousands of more dollars.

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Look for our Social Security Guide coming in 2023!


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