MEDICARE DECISIONS MADE EASIER

YOUR MEDICARE GUIDE

Medicare overview information on this brochure was developed by Transamerica Resources, Inc. to help consumers understand certain aspects about Medicare. Viewing this Medicare overview does not require you to enroll in any Transamerica insurance products. Insurance products are underwritten and offered through separate Transamerica companies.

This material is being provided to help explain Medicare in an easy-to-read format. It's for educational purposes only. Medicare has neither reviewed nor endorsed this information.

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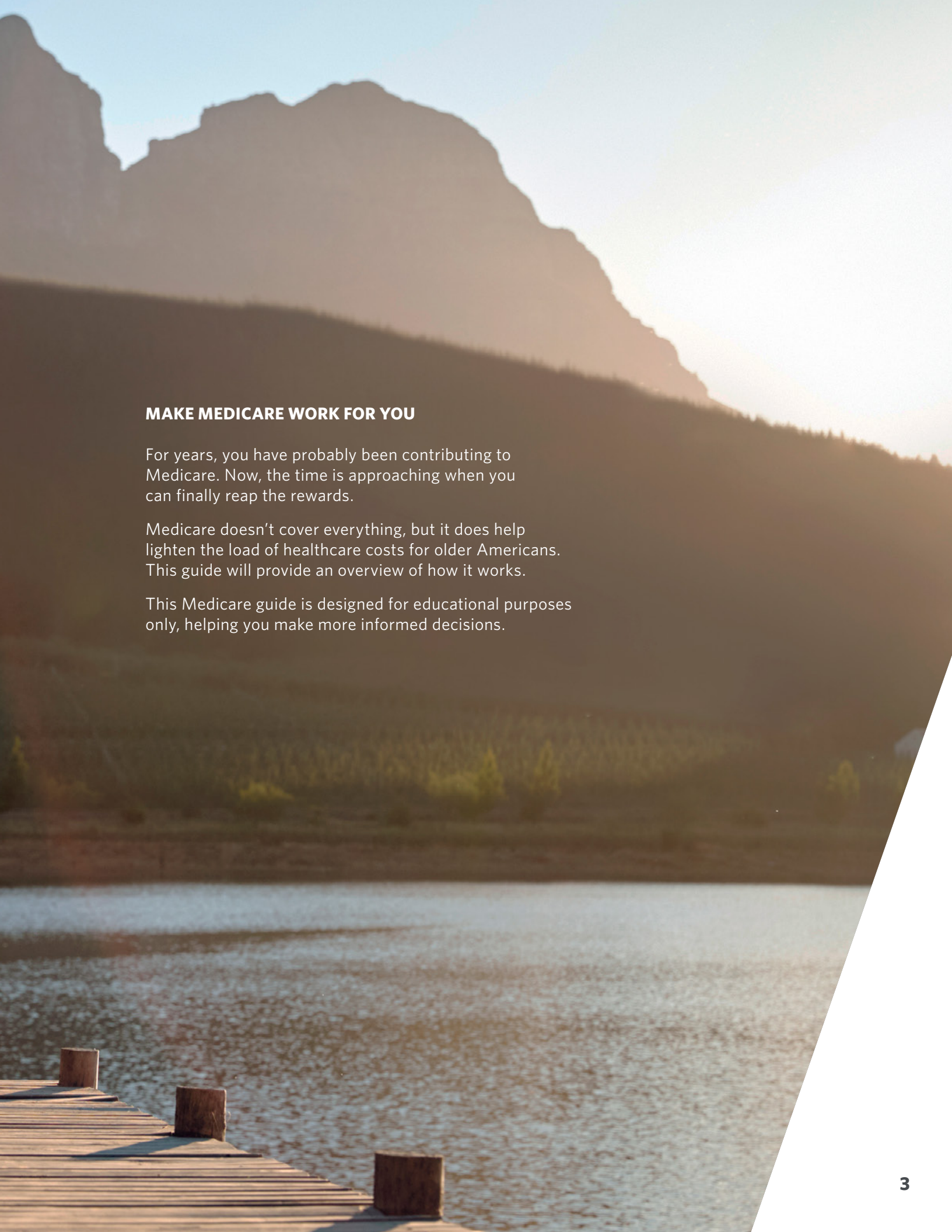
MAKE THE MOST OF YOUR MEDICARE BENEFITS WHILE MANAGING HEALTHCARE COSTS.



MAKE MEDICARE WORK FOR YOU

For years, you have probably been contributing to Medicare. Now, the time is approaching when you can finally reap the rewards.

Medicare doesn't cover everything, but it does help lighten the load of healthcare costs for older Americans. This guide will provide an overview of how it works.

This Medicare guide is designed for educational purposes only, helping you make more informed decisions.

GETTING STARTED

THIS GUIDE IS MEANT TO GIVE YOU A BASIC UNDERSTANDING OF MEDICARE

For the most complete and comprehensive information on Medicare, visit the federal government's official site, **Medicare.gov**. Check there for the free *Medicare & You* handbook, which is updated annually. For guidance on individual circumstances, contact Social Security, State Health Insurance Assistance Programs (SHIP), or companies offering Medicare Advantage* and Medicare Part D plans and Medigap policies directly.

The nonprofit Medicare Rights Center also provides easy-to-understand information at **medicareinteractive.org**. The nonprofit *Transamerica Center for Health Studies* website also provides clear information at:

transamericainstitute.org > Health & Wellness > Health Care Guides > Medicare Guide.

*Medicare Advantage is not available in Alaska.

THIS GUIDE EXPLAINS:

- What each part of Medicare covers
- When to enroll to avoid penalties
- What Medicare doesn't cover
- Budgeting for your premiums
- How Medicare works with health savings accounts
- Considerations for spouse or partner, if applicable

GLOSSARY AT A GLANCE

These are some terms you may have heard.

ORIGINAL MEDICARE

Coverage managed by the federal government. You can choose this option, or you can buy a plan from a private insurer instead.

MEDICARE ADVANTAGE

A type of Medicare approved health insurance plan from a private company you can choose to cover most of your Part A and Part B benefits instead of Original Medicare. It usually also includes drug coverage (Part D).

MEDIGAP

If you sign up for Original Medicare to cover your Part A and Part B, you can buy a Medigap policy (known as Medicare Supplement Insurance) from a private insurance company to help pay your share of costs that aren't covered by Original Medicare. You can only buy Medigap if you have Original Medicare.

DEDUCTIBLE

The amount of costs you pay out of pocket before coverage kicks in.

CO-PAY

A flat dollar amount you pay upfront for certain services.

CO-INSURANCE

The percentage of the cost for covered services you pay after the deductible has been paid.

PREMIUM

A periodic payment you make to Medicare, an insurance company, or a healthcare insurance plan for health or prescription drug coverage.

WHAT'S COVERED UNDER ORIGINAL MEDICARE PARTS A, B, D, MEDICARE ADVANTAGE AND MEDIGAP

PART A

HOSPITALS (AND OTHER MEDICAL FACILITIES)

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care services

Part A is generally referred to as hospital insurance or coverage for inpatient hospital stays and hospice care. Most people don't pay a monthly premium for Part A because they've already paid Medicare taxes on their paychecks or their spouse's paychecks for at least 10 years. Otherwise, you may pay monthly premiums depending on whether you've ever paid any Medicare taxes. With Part A, there's generally a deductible amount to pay before Medicare steps in and covers your bill for inpatient stays in a facility. Deductibles are applied to benefit periods. A benefit period starts when you're admitted as an inpatient at a hospital or skilled nursing facility and ends after you've been out of the hospital and haven't received skilled care in any other facility for 60 days in a row. You'll also pay co-insurance for longer stays. To learn more about premium, deductible, and co-insurance amounts, visit **Medicare.gov**.

OUT-OF-POCKET COSTS FOR PART A

Premium	Typically Part A doesn't have a monthly premium.
Deductible	Part A deductibles aren't annual amounts. Deductibles are calculated by benefit periods (see definition above), so you may have to pay more than one deductible per year.
Co-payment	After your deductible is met, you will pay a flat co-payment amount for certain qualified services. After your co-payment periods are exhausted, you're responsible for all costs.
Out-of-Pocket	There is no out-of-pocket maximum for Part A.

PART B

DOCTOR SERVICES, OUTPATIENT CARE, MEDICAL SUPPLIES, PREVENTIVE CARE

- Medically necessary services, including services to diagnose or treat a condition
- Preventive services, such as flu shots or tests that can detect illness early on
- Ambulance service (only when other transportation could endanger your health and to the nearest appropriate facility that can give you the care you need)
- Medically necessary durable medical equipment including crutches, wheelchairs, etc.
- Mental healthcare, in some instances
- A second opinion on surgeries deemed medically necessary

Part B premiums vary by income. Your monthly premium is typically deducted from the monthly Social Security benefit payments you receive.

OUT-OF-POCKET COSTS FOR PART B

Premium	Paid monthly, typically deducted from your Social Security payment. Visit **Medicare.gov** for current rates.
Deductible	Must be paid before Part B begins to cover qualified services.
Co-payment	After your deductible is met, you will pay 20% for qualified services or items as long as your doctor or healthcare provider accepts the Medicare approved amount as full payment – called accepting assignment. Most doctors, providers, and suppliers accept assignment, but always check to make sure that yours do. If your provider doesn't accept assignment your out-of-pocket costs may be higher.
Preventive Benefits	Some preventive services are covered at 100% by Part B. See **Medicare.gov** for more details and for which services are covered.
Out-of-Pocket	There is no out-of-pocket maximum for Part B.

PART C

MEDICARE ADVANTAGE

The two ways to get Medicare are Original Medicare (Parts A & B), or Medicare Advantage (Part C). This includes Parts A, B and sometimes Part D.

OUT-OF-POCKET COSTS FOR PART C

Premium	Paid monthly, varies by plan.
Deductible	Must be paid before Medicare Advantage plans begin to cover qualified services, varies by plan.
Co-Insurance	After your deductible is met, you'll pay a portion of covered services, varies by plan. Out-of-pocket limit varies based on plan.

LEARN MORE ONLINE

To see how Original Medicare and Medicare Advantage compare, visit:
www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices

MEDICARE WON'T COVER ALL YOUR HEALTH EXPENSES, BUT IT WILL HELP YOU WITH SOME OF THE COSTS.

PART D

PRESCRIPTION DRUGS

Medicare prescription drug coverage is referred to as Part D. Part D is offered by private insurance companies who follow rules set by Medicare. You don't need it right away if you have drug coverage from other sources such as an employer or union, but be sure to sign up if that coverage is ending soon. (If you don't sign up for Part D coverage once you're eligible or once your other prescription drug coverage has ended, you may be subject to a late enrollment penalty once you do sign up.)

OUT-OF-POCKET COSTS FOR PART D

Premium	Paid monthly, varies by plan and you may pay more based on your income.
Deductible	Must be paid before Part D begins to cover qualified services, varies by plan. Some plans have no deductible.
Co-Payments & Co-Insurance	After your deductible is met, you'll pay a portion of covered services, which varies by plan and pharmacy, until you reach the coverage limit. Once you reach the coverage limit your out-of-pocket costs may increase until you reach your out-of-pocket maximum.

LEARN MORE ONLINE

To find out more about Part D coverage, visit:
www.medicare.gov/drug-coverage-part-d

MEDIGAP

MEDICARE SUPPLEMENT INSURANCE

Medigap plans, also known as Medicare supplement insurance, can help pay your share of costs for services covered by Original Medicare (Part A and Part B) including deductibles, co-payments, and co-insurance.

While each standardized Medigap plan offers different benefits, all plans must offer hospital co-insurance coverage after 365 days of Medicare coverage is used, full or partial coverage for Part B's 20% co-insurance or co-payment costs, and Part A hospice co-insurance or co-payment costs. Some plans also include out-pocket-maximums, and cover services that Original Medicare doesn't cover, like foreign travel emergency care.

LEARN MORE ONLINE

View what each Medigap plan covers at:
www.medicare.gov/health-drug-plans/medigap/basics/compare-plan-benefits

CHOOSING MEDICARE COVERAGE

STEP 1: Pick your Medicare coverage

Original Medicare
Provided through federal government

Part A
Hospital

+

Part B
Medical

OR

Medicare Advantage
Provided by private insurance carrier

Part C
Hospital, medical, and (usually) prescription drug

STEP 2: Want prescription drug coverage?

Part D
Prescription Drug

Provided by private insurance carrier

Part D
Prescription Drug

Typically included in Part C, if not, you may enroll

STEP 3: Want to reduce out-of-pocket costs?

Medicare Supplement
Insurance

Provided by private insurance carrier

You May Not Enroll
in Medicare Supplement Insurance

With Medicare Advantage

ENROLLING IN MEDICARE

ARE YOU TURNING 65?

YES

Are you currently receiving Social Security benefits?

NO

You may qualify for Medicare if you receive certain disability benefits or have specific conditions, such as end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease.

NO

Will you have healthcare coverage after you turn 65?
You could have coverage through your employer if you aren't planning to retire or coverage through your spouse.

YES

You'll automatically be enrolled in Part A and Part B and your monthly premiums will be deducted from your Social Security payment.

NO

Visit **ssa.gov/medicare/sign-up** to enroll during your seven-month Initial Enrollment Period (IEP). Your IEP is three months before you turn 65, your birthday month, and three months after.

YES

You may be able to delay in enrolling in Medicare Part A and/or B. Check to ensure your coverage qualifies. **Remember:** Even if you don't sign up for Part A, you may still have to enroll in Part B to avoid future penalties.
See **When to Enroll** on page 14 for more details.

LEARN MORE ONLINE

Find out when and how to enroll at:
www.medicare.gov/basics/get-started-with-medicare/sign-up

WHEN TO ENROLL

PART A, PART B, OR PART C

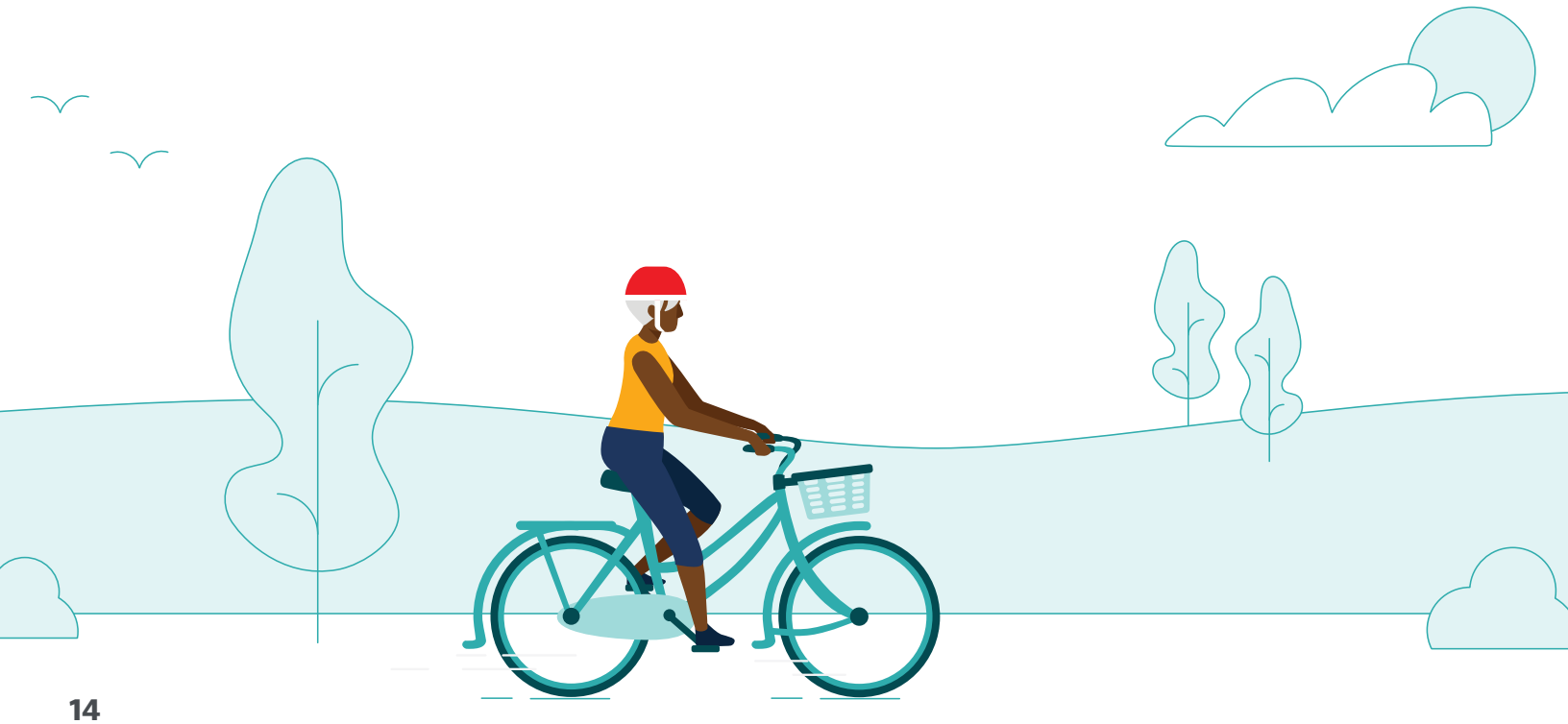
There's a seven-month period in which you can sign up for Medicare. This is called your initial enrollment period (IEP).

It spans three months before and three months after your 65th birthday month. If you plan on retiring at 65, you will want to sign up for Part A & B or Part C during your IEP to avoid penalties.

Remember you can enroll in Medicare through Original Medicare (Part A & B) or through Medicare Advantage (Part C).

If you plan on working (or your spouse is) after age 65 and you're covered by a group health plan, you may only need to enroll in Part A when you are first eligible and can delay Part B (or Part C) coverage. You'll want to talk to your benefits administrator to help you decide when you should enroll in Part B. Note that COBRA (which is continued health coverage under a group plan after a job loss, for example) doesn't count as employer coverage.

Then, beginning the month after your job or your coverage through your employer or spouse's employer ends (whichever comes first), you'll have eight months to enroll in Part B or Part C to avoid facing penalties. This is called your special enrollment period (SEP). Make sure to plan ahead to avoid any gaps in coverage.



PART D

Avoid penalties by making sure you don't go 63 days or more in a row without Prescription drug coverage, whether it's from a Medicare Advantage Plan, employer, union, or other provider.

If you don't already have drug coverage, you can enroll when you're first eligible for Medicare. The penalty for late enrollment in Part D is generally a permanent extra monthly fee.

MEDIGAP

You can enroll in Medicare Supplement Insurance when you sign up for Medicare Part B.

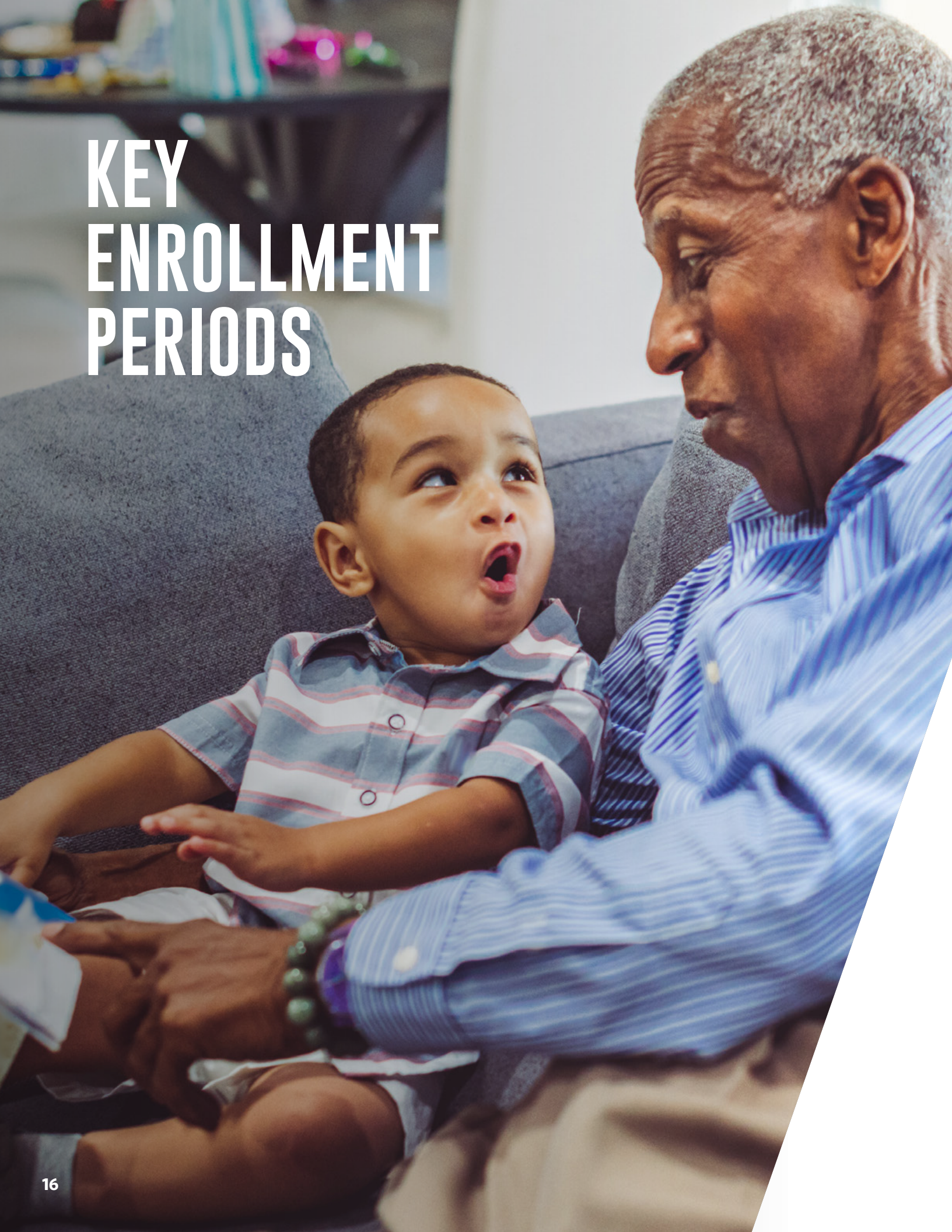
If you're looking to supplement your Original Medicare coverage to help with additional costs, the best time to buy a Medigap plan is during your one-time Open Enrollment Period that starts with your Medicare Part B enrollment and lasts six months. If you don't sign up for a Medigap plan during this Open Enrollment Period, you may not be able to buy a Medigap plan. And unless you have a guaranteed issue right, you may be required to answer medical questions.

LEARN MORE ONLINE

To view information about potential penalties, visit:
www.medicare.gov/basics/costs/medicare-costs/avoid-penalties

WHEN CHOOSING MEDICARE COVERAGE, MAKING DECISIONS ON TIME WILL ALLOW YOU TO AVOID PENALTIES.

KEY ENROLLMENT PERIODS



ANOTHER CHANCE TO ENROLL (OR SWITCH COVERAGE)

ANNUAL ENROLLMENT PERIOD (AEP)

The time each year when you can change your Medicare coverage choices. It usually runs from mid-October to early December. During this time:

- If you have Original Medicare, you can switch to a Medicare Advantage plan — or vice versa.
- You can switch from a Medicare Advantage plan with drug coverage to one without — or vice versa.
- You can join or drop a Medicare prescription drug plan.
- You can also update your coverage by switching to a new plan from your current insurer or switching to a new insurer.

If you choose to make a change during the AEP, your new coverage won't begin until January 1.

> **Tip:** If you're content with your current coverage, you're not required to make a change. In most cases, your current Medicare plan will automatically renew on January 1.

MEDICARE ADVANTAGE (PART C) OPEN ENROLLMENT PERIOD

This period takes place from January 1 to March 31 annually. It allows individuals enrolled in a Medicare Advantage plan to make a one-time election to either go to another Medicare Advantage plan with or without prescription drug coverage or Original Medicare. You'll also be able to enroll in a Medicare prescription drug plan. In either case, your new coverage will start on the first day of the month following the month you make a change.

WHAT YOU'LL COVER ON YOUR OWN

EXAMPLES OF WHAT ORIGINAL MEDICARE DOESN'T COVER

- Long term care (basic custodial care)
- Most dental care
- Routine eye exams
- Hearing aids
- Foreign travel emergency

> **Tip:** Download Medicare's "What's Covered?" app.
> Search 'Medicare' or 'what's covered' wherever you get your apps.

MEDIGAP OPTIONS

IF YOU OPT FOR ORIGINAL MEDICARE AND CHOOSE TO ADD A MEDIGAP POLICY, THERE ARE 10 STANDARDIZED PLANS.

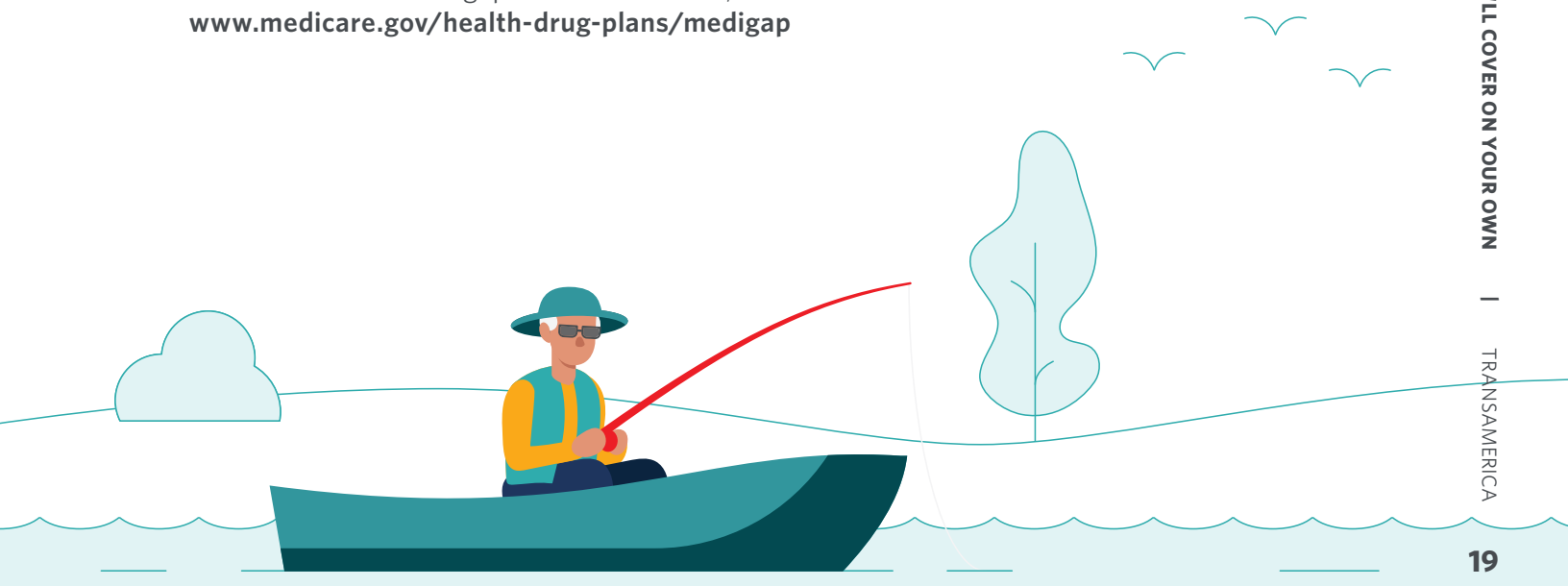
Plans are named by letters A-D, F, G, and K-N. Each plan labeled with the same letter will have the same benefits, no matter the company or price. However, the benefits are different in each lettered plan — allowing you to choose one that best meets your needs.

Once you enroll in a Medigap plan, your enrollment is guaranteed as long as you pay the premium (premiums may change each year). Note that not all plans are offered in every state. Find out what's covered by each type of Medigap plan on the **Medicare.gov** Medigap Policies page.

> **Important:** In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

LEARN MORE ONLINE

For details about Medigap and how to enroll, visit:
www.medicare.gov/health-drug-plans/medigap



FINANCIAL CONSIDERATIONS

BUDGETING FOR PREMIUMS

Talk to your financial professional about your gross income.

The higher your income, the more you can expect to pay in premiums for Part B and Part D.[1] The extra amount will be deducted from your monthly Social Security payment or billed to you.

What you'll pay is determined by your Modified Adjusted Gross Income (MAGI) from your federal tax return.[2]

Premiums for Part B and Part D are based off your federal tax return provided by the IRS **from two tax years prior**. If you must pay higher premiums, a sliding scale is used to make adjustments, based on your MAGI. MAGI is the sum of your Adjusted Gross Income (AGI), tax exempt interest, untaxed foreign income, Social Security benefits not included in gross income, and certain deductions for AGI.[2] Be aware that Medicare has different thresholds for MAGI than the IRS.

LEARN MORE ONLINE

To learn more about how MAGI could affect premiums, visit:
www.ssa.gov/benefits/medicare/medicare-premiums.html

[1] "Premiums: Rules For Higher-Income Beneficiaries," Social Security Administration, accessed August 2023
[2] "Modified Adjusted Gross Income (MAGI)," HealthCare.gov, accessed August 2023

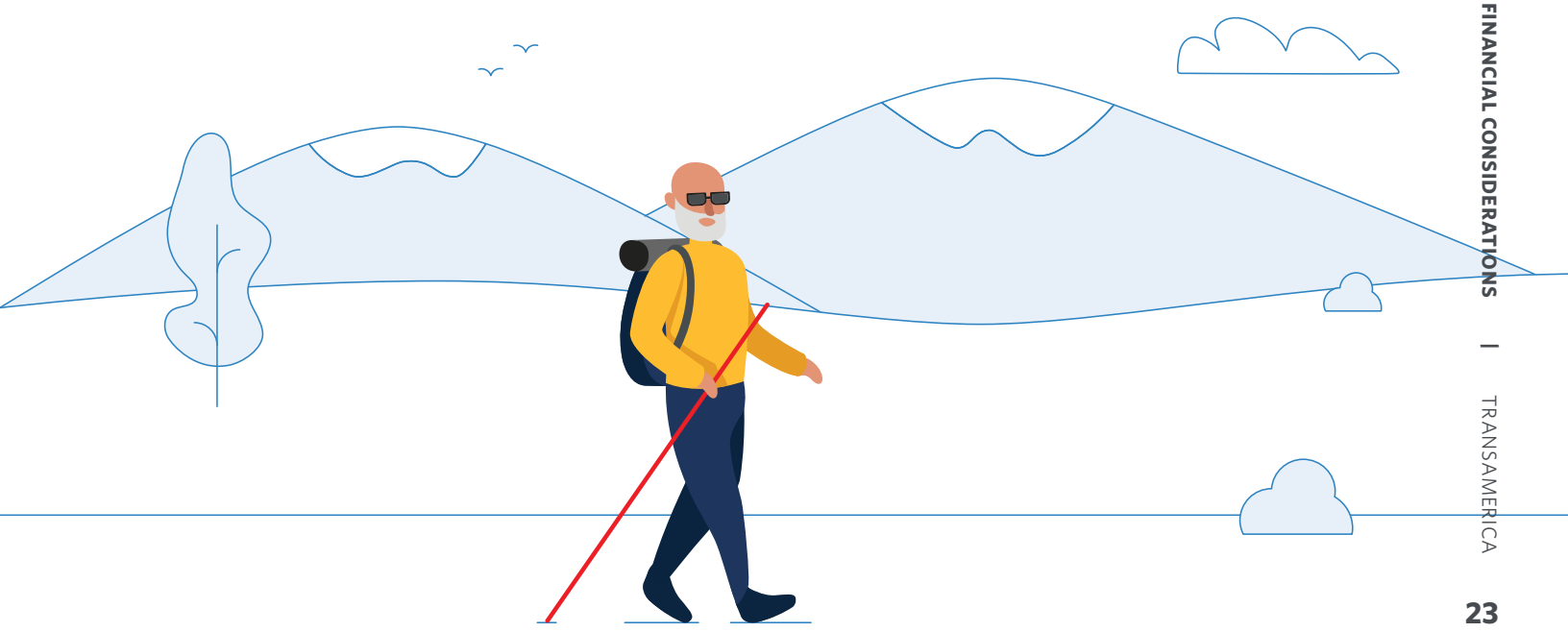
Did you know?

You and your financial professional can evaluate options for limiting your gross income. Note that some options may save you money on Medicare but divert you from your overall financial goals.

QUESTIONS YOU MIGHT CONSIDER:

- If you have a second home you plan to sell, should you sell before age 63, so it doesn't boost your gross income?
- Can you maximize contributions to a retirement account, Roth IRA, or health savings account?
- Should you consider making a charitable gift?
- Do you have any options for offsetting your capital gains?
- Do you have any tax-free income sources?

We don't give tax advice, so consult your financial professional for answers on any of these topics.



MEDICARE & TAX-ADVANTAGED ACCOUNTS

MEDICARE & TAX-ADVANTAGED ACCOUNTS

There are two types of tax-advantaged accounts you may use to pay for expenses during retirement: Health Savings Account (HSA) or Health Reimbursement Account (HRA).

UNDERSTANDING HSAs

Employees and their employers may make contributions to their HSA during their working years. Employee contributions are usually pretax deductions and employer contributions are not taxable to the employee. These contributions are exempt from federal income and FICA (Social Security and Medicare) taxes. Employers may also make HSA contributions on an employee's behalf. These contributions are not taxable to the employee. Employees earn tax-free interest on their HSA balances, and distributions for eligible healthcare expenses are not taxable.

Did you know?

IF YOU HAVE AN HSA, KEEP IN MIND THAT:

Contributions to your HSA must stop once you enroll in Medicare. Premium-free Part A coverage can begin six months back from the date you apply.

> **Medicare.gov** suggests stopping contributions to an HSA at least six months before applying for Medicare to avoid tax penalties.

You still can use money from your HSA to pay for qualified healthcare expenses in retirement. Qualified medical expenses are generally the same types of services and products that otherwise could be deducted as medical expenses on your yearly income tax return. Some qualified medical expenses, like doctors' visits, lab tests, and hospital stays, are also services covered by Medicare. Services like dental and vision care are qualified medical expenses, but aren't covered by Medicare.

LEARN MORE ONLINE

For a list of qualified healthcare expenses, visit:
www.irs.gov/publications/p969

MEDICARE & TAX-ADVANTAGED ACCOUNTS

UNDERSTANDING HRAs

There are many different types of HRAs and how they interact with Medicare can be tricky. In certain circumstances and with certain types of accounts, you may use an HRA to pay for qualified medical expenses or even premiums related to Medicare coverage. Here's what you should know:

HRAs are employer-sponsored benefit plans that allow employees to use tax-free money to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA) or HSA, the employer owns the HRA and completely funds it. Employees don't contribute and it doesn't count as taxable income.

HRAs are often coupled with a HDHP but there is no requirement that they must be, and there are no government-set out-of-pocket maximum limits specifically for plans linked to HRAs. HRAs cannot be taken with an employee if they should leave the employer. There are some exceptions, though, such as a retirement HRA.

> **As an employer-owned and funded account**, the employer chooses not only how much to put into the HRA, but also what IRS eligible expenses it will cover.

ACTIVE EMPLOYEE HRA

An Active Employee HRA is one type that does not work with any Medicare insurance plans. Since Medicare is an individual insurance option, and the HRA only works with a traditional group health insurance plan, the two aren't compatible for active employees. An HRA's funds generally revert to the employer on termination of employment, including at retirement.

QUALIFIED SMALL EMPLOYER HRA (QSEHRA)

The QSEHRA is one way employers can reimburse Medicare premiums. A QSEHRA is for employers with fewer than 50 full-time employees. They can offer this HRA to reimburse their employees for eligible expenses and insurance premiums.

All full-time employees are automatically eligible for the QSEHRA, no matter their insurance status. However, if they have an insurance plan that qualifies as MEC (Minimum Essential Coverage), then all of their eligible QSEHRA reimbursements will be 100% tax-free. Medicare Parts A and B together or Part C count as MEC.

INDIVIDUAL COVERAGE HRA (ICHRA)

Under the ICHRA, eligible employees and their dependents must have a qualifying type of individual health insurance in order to participate. This can include either Medicare Part A and B together or Part C.

RETIREE HRA (RHRA)

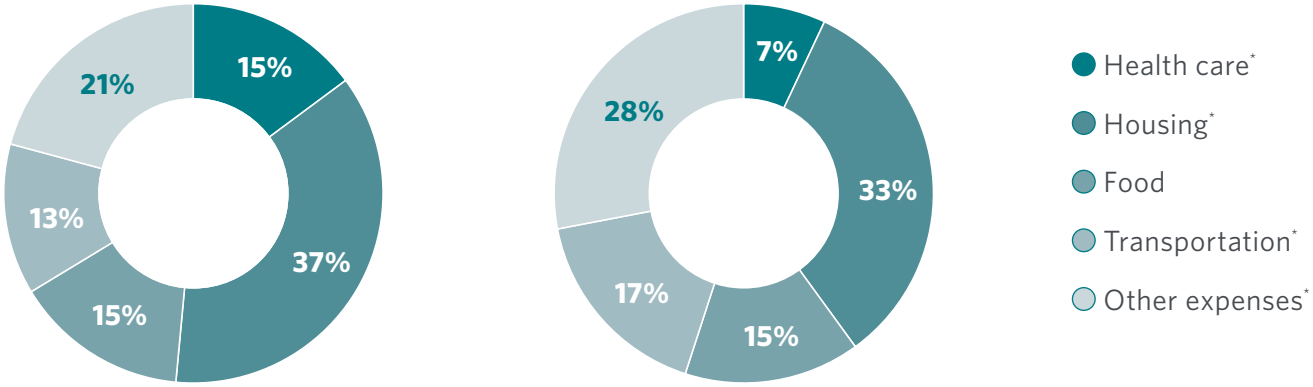
A RHRA is designed to help retirees pay for policy-eligible medical expenses during retirement, including individual health insurance and Medicare premiums. With a RHRA, funds are deposited in a lump-sum upon retirement/separation of service. The funds are invested once deposited and can be used immediately upon deposit. Employers also have flexibility to tailor post-retirement HRAs in a number of ways, including by designing them to only pay for "Medigap" supplemental health plan premiums, for instance.

> **Employers may establish retiree HRAs** to reimburse premiums for Medicare and Medicare supplemental health insurance (Medigap), as well as other medical care expenses.

HEALTH CARE ACCOUNTED FOR A LARGER SHARE AND AMOUNT OF TOTAL HOUSEHOLD SPENDING FOR MEDICARE HOUSEHOLDS THAN FOR NON-MEDICARE HOUSEHOLDS IN 2021

Medicare Households spent an average of $6,557 on health care, $16,408 on housing, $6,606 on food, $5,752 on transportation, and $9,363 on other expenses.

Non-Medicare Households spent an average of $4,598 on health care, $22,426 on housing, $10,281 on food, $11,630 on transportation, and $18,834 on other expenses.



Medicare (total expenditure: $44,686)

Non-Medicare (total expenditure: $67,769)

*Estimate statistically significant from non-Medicare households at p<0.05 level
KFF analysis of the Bureau of Labor Statistics Consumer Expenditure survey Interview and Expense Files, 2021

65 million

people are enrolled in Medicare coverage either through Original Medicare or Medicare Advantage.**

91%

of adults on Medicare rate their insurance positively.***

**"Medicare Enrollment Numbers," Center for Medicare Advocacy, June 2023
***"KFF Survey of Consumer Experiences with Health Insurance," KFF, June 2023

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LEARN MORE ONLINE:

medicare.gov

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