Grace Global Alliance

An Independent Association of Christian Churches & Ministers

Healthcare in Retirement
Tax Year 2017

Prepared for:

Grace Global Alliance
Ministers & Churches

Prepared by:

John Terry
Grace Global Alliance
100 Plaza Carmona Place
Hot Springs Village AR 71909
Website: www.GraceGlobalAlliance.com

June 20, 2017

Table of Contents

Medicare Parts A and B

Consider What Medicare Does and Does Not Cover

Medicare is a health insurance program operated by the federal government. Benefits are available to qualifying individuals age 65 or older, certain disabled individuals under age 65, and those suffering from end-stage renal disease. The traditional Medicare program consists of two main parts: Part A, Hospital Insurance and Part B, Medical Insurance. There are clearly defined limits as to what Medicare will, and will not, pay.

Medicare (Part A) 2017 Hospital Insurance Covered Services per Benefit Period

Service	Benefit	Medicare Pays	You Pay
Hospitalization: Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic X-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	Medicare pays all covered costs for first 60 days, except the first $1,316. For the 61st through 90th days, it pays all except $329 a day. There are also 60 nonrenewable reserve days that can be used when the 90 days are past. Medicare pays all except the first $658 for each reserve day.		
Post-hospital skilled nursing facility care (in a facility approved by Medicare): You must have been in a hospital for at least three days in a row and enter the facility within 30 days after having been discharged from the hospital.	**First 20 days.**	All costs.	Nothing.
	Next 80 days.	All but $164.50	$164.50 per day
	Medicare and private insurance will not pay for most nursing home care, and you pay for custodial care.		
Home health care: Post-institutional care. You must have been in a hospital for at least three days in a row or have been in a skilled nursing facility following a hospital stay.	Pays the cost of 100 home visits, if made under a physician's treatment plan.	Full cost.	Nothing for services; 20% of approved amount for durable medical equipment.
Hospice care: May exceed the 210 days of care if recertified as terminally ill.	Two 90-day periods and one 30-day period.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
Blood.	Blood.	All but first three pints.	For first three pints.

Medicare (Part B) 2017 Medical Insurance Covered Services per Calendar Year Standard Monthly Premium: $134.00[1]

Service	Benefit	Medicare Pays	You Pay[2]
Medical expense: Doctor's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of hospital. Some insurance policies pay less (or nothing) for hospital outpatient medical services in a doctor's office.	80% of approved amount (after $183.00 deductible). 50% of approved charges for most outpatient mental health services.	$183.00 deductible[3] plus 20% of approved amount and limited charges above approved amount.[4] 50% of approved charges for mental health services.
Home health care[5].	Unlimited, if made under a physician's treatment plan.	Full cost.	Nothing for services; 20% of approved amount for durable medical equipment.
Outpatient hospital treatment.	Unlimited if medically necessary.	80% of approved amount (after $183.00 deductible).	$183.00 deductible[2] plus 20% of balance of approved amount.
Blood: Any blood deductibles satisfied under Part B will reduce the blood deductible requirements.	Blood.	80% of approved amount (after first three pints).	$183.00 deductible[2] plus first three pints plus 20% of balance of approved amount.

Note: If the period of hospitalization covers two calendar years, no new deductible is required for the new year. These figures are for 2017 and are subject to change each year.

[1] Most people who receive Social Security benefits will pay less than this amount. This is because the 2017 Part B premium increased more than the 2017 cost-of-living increase for Social Security benefits. Those who pay their Part B premium by having it deducted from their monthly Social Security benefits will pay $109.00 (on average). Social Security is expected to advise each Social Security recipient of the exact amount early in 2017.

[2] You pay for charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered.

[3] Once you have had $183.00 of expense for covered services in 2017, the Part B deductible does not apply to any further covered services you receive the rest of the year.

[4] Federal law limits charges for physician services.

[5] Home health care is provided under Part B only if not covered under Part A.

Part B Premium for Certain Beneficiaries

Pursuant to one provision of the Bipartisan Budget Act of 2015, certain Medicare beneficiaries will pay a higher Part B premium in 2017. The minimum premium for those in this group will be $134.00. Individuals in this group include:

- Medicare beneficiaries not receiving Social Security benefits.
- Those who enroll in Part B for the first time in 2017.
- Those who have both Medicare and Medicaid, and Medicaid pays the Medicare premiums.
- Those whose income in 2015 exceeded certain limits. The *total* premium for those in this group will also include an income-related monthly adjustment amount. Based on their filing status and income.[1]

The table below shows the 2017 Part B premiums for these Medicare beneficiaries.

Unmarried Individuals	Married Filing Jointly	Total Monthly Premium
Less than $85,000	Less Than $170,000	$134.00
$85,001 to $107,000	$170,001 to $214,000	$187.50
$107,001 to $160,000	$214,001 to $320,000	$267.90
$160,001 to $214,000	$320,001 to $428,000	$348.30
More than $214,000	More than $428,000	$428.60

Married Filing Separately	Total Monthly Premium
Less than $85,000	$134.00
$85,001 to $129,000	$348.30
More than $129,000	$428.60

[1] The measure used is modified adjusted gross income. Generally adjusted gross income plus any tax free interest or any excluded foreign earned income. An appeals process is available in case of a major life change such as the death of a spouse, divorce, or marriage.

Medicare Part C – Medicare Advantage

The original Medicare program, created in 1965, consists of Part A (hospital insurance) and Part B (medical insurance) and operates as a "fee-for-service" system. Under this program, a Medicare beneficiary can go to any physician or health facility nationwide which accepts Medicare payments.

An Alternative To Traditional Medicare

In 1997, the federal government created, as Medicare Part C, the Medicare+Choice program. This new program was designed to give Medicare beneficiaries access to a wide array of more cost-effective, private health plan choices, as an alternative to the traditional Parts A and B. In 2003, Medicare+Choice was renamed as "Medicare Advantage", as part of the Medicare Prescription Drug, Improvement, and Modernization Act.

Options Under Medicare Advantage

In general, each Medicare beneficiary is entitled to choose to receive benefits through either the original Medicare fee-for-service program under Parts A and B or through a Medicare Advantage plan. The Medicare Advantage options include:

- Health maintenance organizations (HMOs),
- Point-of-service (POS) plans,
- Preferred provider organizations (PPOs),
- Provider sponsored organizations (PSOs); and
- Private fee-for-service plans.

Benefits Under Medicare Advantage

Medicare Advantage plans are required to provide the same benefits that are covered under the traditional fee-for-service plan, except for hospice care. The plans can offer supplemental benefits not covered by the traditional plan. Medicare Advantage plans are prohibited from denying or limiting coverage based on health-status related factors. The only exception is that Medicare Advantage plans do not have to accept enrollees who have end-stage renal disease.

Making a Choice

Once a plan has been elected, that choice will remain in effect until the beneficiary changes it or the plan chosen no longer services the area in which the beneficiary resides.[1] If a beneficiary fails to make an election, he or she will remain in the traditional fee-for-service program.

- **Initial Medicare eligibility:** Beneficiaries who enroll in a Medicare Advantage plan when they first become eligible for Medicare benefits can change to the fee-for-service plan at any time during their first 12 months of enrollment. During this period they will have an extended period of guaranteed access to Medigap plans.
- **Annual enrollment:** An annual enrollment period takes place each fall, from October 15 through December 7. Elections made during this annual enrollment period take effect January 1st of the following year. As a part of the annual enrollment, Medicare beneficiaries will be provided with information about each health plan available to them. The purpose of this information is to allow Medicare beneficiaries to make informed health care choices, based on comparative data regarding quality and performance.
- **Special enrollment periods:** Special enrollment periods are available after the end of the continuous open enrollment if: (1) a plan is discontinued; (2) the Medicare beneficiary moves; (3) the plan violates its contract with Medicare; or (4) the Medicare beneficiary encounters exceptional conditions (to be specified in regulations).

[1] Not all Medicare Advantage options are available in all geographical areas.

Medicare Part D – Prescription Drug Coverage

Medicare Part D provides insurance coverage for prescription medications. Under this program, insurance companies and other private firms contract with Medicare (Medicare pays most of the premium) to provide prescription drug benefits to Medicare beneficiaries.

Each eligible Medicare beneficiary must select a drug plan and pay a monthly premium to receive the drug coverage. All drug plans (the choice varies by state) must provide coverage at least as good as the standard coverage specified by Medicare. Some plans may offer extra benefits such as no deductible, higher coverage limits, or cover additional drugs, in exchange for a higher monthly premium. Individuals with limited income and resources may qualify for help in paying for drug coverage.

Making a Choice

There are a number of factors to consider in making a choice about drug plans, including:

- **Initial enrollment:** A new Medicare beneficiary may enroll in a prescription drug plan during the seven-month period beginning three months before he or she turns age 65 until three months after reaching age 65. An individual who has lost "creditable coverage" (prescription drug coverage from some other source that is at least as good as the standard Medicare prescription coverage) has 63 days to select and join a Medicare prescription drug plan. An eligible beneficiary who does not enroll in a prescription drug plan within the prescribed time limits faces a penalty for late enrollment.
- **Penalty for late enrollment:** Individuals who delay joining a Medicare prescription drug plan beyond their initial eligibility face a monthly premium that will increase by at least 1% per month for each month of delay. This increased premium applies for as long as the individual is enrolled in a Medicare drug plan.
- **Changing plans:** Each year, from October 15 to December 7, a beneficiary can change to a different prescription drug plan.

Medicare Part D - Prescription Drug Coverage

- **Current prescription coverage:** Individuals who currently have prescription drug coverage from another source may not wish to enroll in a Medicare prescription drug program. In some cases the benefits provided under these other plans are better than those provided under the standard Medicare prescription drug plan.
- **Medication coverage:** Consider what medications are needed. Compare the needed medications with those covered by each plan. Each plan will have a list (termed a "formulary") showing the drugs (generic and brand-name) the plan will pay for.
- **Out-of-pocket cost:** A prescription drug plan can vary in how much it charges and how much coverage is provided. Issues such as the monthly premium, yearly deductible, any co-insurance or co-payments, and coverage limits must all be considered.
- **Pharmacy convenience:** Not all pharmacies will be contracted with all plans. Some plans will allow a beneficiary to receive prescriptions by mail.
- **Future health changes:** Even though an individual takes few or no medications now, joining a prescription drug plan now means paying the lowest possible monthly premium. Future health changes may require increased use of prescription drugs.

Standard Coverage

The standard coverage for 2017 as set by Medicare is shown in the following table:

	$400 Deductible	$401 to $3700	$3701 Until Out of Pocket Totals $4550	Above $4550 in Out of Pocket Costs
Individual Pays	$400.00	25% up to $825	$3,325	5%
Plan Pays	$0.00	75% up to $2475	$0.00	95%
Total Drug Expense	$400.00	$3,700.00	$7,025	

In 2017, once total drug spending reaches $3,700 (where the coverage gap begins), a Medicare Part D enrollee will pay 40% of the plan's cost for covered brand-name prescription drugs and 51% of the plan's cost for covered generic drugs. The amount paid by the enrollee – as well as the discount paid by the drug company – count as "out-of-pocket" spending, helping the enrollee get out of the coverage gap.

Monthly Adjustment Amount

Beginning in 2011, the Patient Protection and Affordable Care Act (PPACA) required Medicare Part D enrollees whose incomes exceed the same thresholds that apply to higher-income Part B enrollees, to pay a monthly adjustment amount. High-income enrollees will pay the regular plan premium to their Part D plan and the monthly adjustment amount to Medicare. The 2017 Part D monthly adjustment amounts are shown in the following tables:

Unmarried Individuals	Married Filing Jointly	Monthly Adjustment Amount
Less Than $85,000	Less Than $170,000	$0.00
$85,001 to $107,000	$170,001 to $214,000	$13.20
$107,001 to $160,000	$214,001 to $320,000	$34.20
$160,001 to $214,000	$320,001 to $428,000	$55.20
More Than $214,000	More Than $428,000	$76.20

Married Filing Separately	Monthly Adjustment Amount
Less Than $85,000	$0.00
$85,001 to $129,000	$55.20
More Than $129,000	$76.20

For Those Who Currently Have Prescription Drug Coverage

Some retirees may already have prescription drug coverage. For these individuals a key step is to compare the current coverage with that provided through a Medicare plan. The benefits administrator or insurance carrier can provide additional information.

- **Coverage provided by employer or union:** If the drug coverage provided by an employer or union is, on average, at least as good as the standard Medicare coverage, the individual may choose to keep the current plan for as long as it is offered. If the plan is discontinued in the future, the individual can join a Medicare drug plan without penalty within 63 days of the coverage ending.

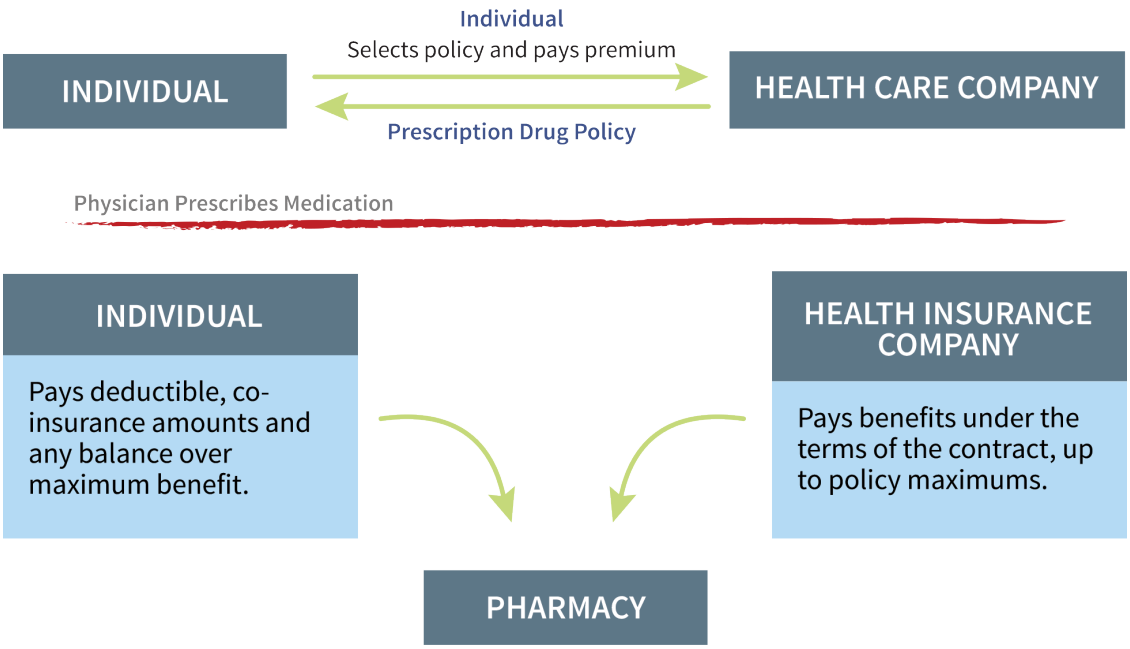
- **Medicare Advantage or other Medicare health plan:** Some Medicare Advantage or other Medicare health plans cover prescription drugs. If a plan does not offer prescription drug coverage, an individual may wish to switch to another Medicare Advantage or other Medicare health plan that does cover prescription drugs, or change to the original Medicare plan and join a Medicare prescription drug plan.
- **Medigap Supplemental Insurance, with prescription drug coverage:** Medigap policies are supplemental health insurance policies designed to fill the "gaps" in health coverage provided under Medicare Parts A and B. A few Medigap policies issued before 2006 included a prescription drug benefit. However, Medigap policies issued January 1, 2006 or later do not include prescription drug benefits. Most prescription drug coverage under the Medigap plans is not, on average, at least as good as the coverage provided under the standard Medicare prescription drug plan.
- **Other government insurance:** Generally, the prescription drug benefits provided by TRICARE, the Department of Veterans Affairs (VA), Federal Employee's Health Benefits Program (FEHB), or Indian Health Services are as good as the standard Medicare prescription drug plan. In most cases it will be to the individual's advantage to keep the current plan. If coverage is lost in the future, the individual can join a Medicare drug plan without penalty within 63 days of the coverage ending.

Seek Professional Guidance

The process of making decisions concerning health care insurance can be confusing and complex. The advice and counsel of trained advisers is strongly recommended. Additional information is also available from:

- **On the web:** www.medicare.gov
- **By telephone:** Contact Medicare at 1-(800) 633-4227 (TTY users: 1-(877) 486-2048)

How Medicare Prescription Drug Coverage Works



Medigap Policies

Medigap policies are supplemental health insurance policies sold by private insurers, designed to fill some of the "gaps" in health coverage provided by Medicare. Although Medicare covers many health care costs, you still have to pay certain coinsurance and deductible amounts, as well as paying for services that Medicare does not cover.

Who Can Buy a Medigap Policy?

Generally, you must be enrolled in the original Medicare Parts A and B before you need to purchase a Medigap insurance policy. Other types of health insurance coverage, such as Medicare Advantage, other Medicare health plans, Medicaid, or employer-provided health insurance, do not work with Medigap policies.

Standardized Policies

Under federal regulations, private insurers can only sell "standardized" Medigap policies. Through May 31, 2010, there were 12 standardized Medigap policies, termed plans A, B, C, D, E, F, G, H, I, J, K, and L. Effective June 1, 2010, plans E, H, I, and J could no longer be sold, and plans M and N were added. Individuals who purchased a plan E, H, I, or J before June 1, 2010 may keep those plans.

The standardized policies allow you to compare "apples with apples." For example, a plan F policy will provide the same benefits, no matter which insurance company it is purchased from. However, a plan C policy will provide different coverage than a plan D policy. All Medigap policies must provide certain "core" benefits.

These standardized plans are not available to those living in Massachusetts, Minnesota, or Wisconsin; there are separate Medigap policies available for residents of these states.

Choosing a Policy

There are two primary factors to consider when choosing a Medigap policy.

- **Needed benefits:** Carefully consider what benefits you are most likely to need; you may not need the most comprehensive plan.

- **Cost:** Once you have decided which benefits you will need, shop for the policy that provides those benefits at the lowest cost.

Policy Costs Can Differ

- **Discounts:** Some insurers may offer discounts to certain classes of people, such as women, non-smokers, or married couples.
- **Medical underwriting:** An insurance company may require you to fill out a detailed questionnaire on your health. The information you provide is used to determine whether or not a policy will be issued, or what premium to charge.
- **Pre-existing conditions:** If you have a "pre-existing condition," a known health problem, before you apply for a Medigap policy, you may have to wait up to six months before that problem is covered.
- **High deductible:** There are two options for Plan F: (1) a standard option, and (2) a "high deductible" option. Choosing the high deductible option means that you must pay more of the costs before the policy begins to provide benefits. Monthly premiums for high deductible policies are typically less.
- **Medicare SELECT:** Medicare SELECT policies are sold in a few states by a few insurers. Except for emergencies, these policies require you to use pre-selected hospitals and physicians.
- **Guaranteed renewable:** Medigap policies issued after 1992 are generally guaranteed renewable. This means that as long as you pay the premiums, are honest about health issues, and the insurance company doesn't go bankrupt, the insurer can't drop your coverage. In some states, policies issued before 1992 may not be guaranteed renewable.
- **Insurer pricing methods:** The table below shows three common methods by which an insurance company will price its Medigap policies:

Pricing Method	Payment	Other Issues
Community (No-Age)	Each insured pays the same premium, regardless of age.	Premiums may increase due to inflation.
Issue-Age	Policy premium is based on your age when you purchase the policy.	Younger buyers pay lower premiums. Premiums may increase due to inflation.
Attained-Age	Premiums are based on your age each year, thus premiums increase annually.	Younger buyers pay lower premiums. Premiums can increase each year. Premiums may also increase due to inflation.

Other Resources

Professional guidance in dealing with any aspect of a Medigap policy is strongly recommended. Other available resources include:

- **Medicare:** The federal government's Centers for Medicare & Medicaid Services (CMS) has a great deal of information available on their website at www.medicare.gov. You can also reach them by phone at (800) 633-4227. TTY users should call (877) 486-2048.
- **State Health Insurance Assistance Programs:** Many states operate health insurance assistance programs designed to provide assistance and information regarding Medicare, Medigap policies, and long-term care policies.
- **State insurance department:** Each state has an insurance department that regulates the sale of all types of insurance within the state. These state agencies can provide information about Medigap policies.

Medigap Policies Compared

Medigap policies are designed to fill the "gaps" in health insurance provided under original Medicare, Parts A and B. These supplemental policies must provide standardized coverage as specified by the federal government.

The following tables compare and contrast the major components of the different policies. Not all policies are available in all states. The policies shown are not available to residents of the states of Massachusetts, Minnesota, or Wisconsin; there are separate standardized policies for residents of those states.

Medigap Plans Sold On or After June 1, 2010[1]

Plan	Core Benefits	Skilled Nursing	Part A Deductible	Part A Hospice	Part B Deductible	Part B Excess Charges	Emergency Foreign Travel	Preventive Care
A	Yes			Yes				Yes
B	Yes		Yes	Yes				Yes
C	Yes	Yes	Yes	Yes	Yes		80%	Yes
D	Yes	Yes	Yes	Yes			80%	Yes
F[2]	Yes	Yes	Yes	Yes	Yes	Yes	80%	Yes
G	Yes	Yes	Yes	Yes		Yes	80%	Yes
K[3]	Some	50%	50%	50%				Yes
L[3]	Some	75%	75%	75%				Yes
M	Yes	Yes	50%	Yes			80%	Yes
N	Yes	Yes	Yes	Yes			80%	Yes

What's included?

- **Core benefits:** Plans A-G, M and N - For Part A hospitalization, cover 100% of all copayments except that for days 1-60 of hospitalization ($1,316 in 2017), plus adding

[1] Through May 31, 2010, 12 standardized Medigap policies could be sold, identified as plans A, B, C, D, E, F, G,H, I, J, K, and L. Effective June 1, 2010, plans E, H, I, and J could no longer be sold, and new plans N and M were added. Individuals who purchased a plan E, H, I, or J before June 1, 2010, may keep those plans.

[2] Plan F has two options: (1) a standard option and (2) a "high deductible" option with a 2017 deductible of $2,200.00.

[3] In 2017, Plan K has an annual out-of-pocket limit of $5,120.00; Plan L has an annual out-of-pocket limit of $2,560.00.

365 lifetime days of hospital coverage after the standard benefit of 150 days is exhausted; 100% of Part B coinsurance amounts[1] after meeting the yearly deductible ($183.00 in 2017); the first three pints of blood. Plans K and L – For Part A hospitalization, cover 100% of all copayments except that for days 1-60 of hospitalization, plus adding 365 lifetime days of hospital coverage after the standard benefit of 150 days is exhausted; for Part B, Plan K pays 50% of the coinsurance amount after the annual deductible is met; Plan L pays 75% of the Part B coinsurance amount after the annual deductible is met; Plan K pays 50% of the cost of the first three pints of blood; Plan L pays 75% of the cost of the first three pints of blood.

- **Part A skilled nursing:** Plans C-G, M and N – Pay 100% of the coinsurance amount Plans C-G, M and N – Pay 100% of the coinsurance amount ($164.50 per day in 2017) for days 21-100 in a skilled nursing facility. Plans K and L – Pay the percentage shown of the coinsurance amount for days 21-100 in a skilled nursing facility.
- **Part A deductible:** Plans B-G, and N – Pay 100% of the Part A deductible ($1,316 in 2017) for the first 60 days of hospitalization. Plans K, L, and M – Pay the percentage shown of the Part A deductible for the first 60 days of hospitalization.
- **Part A hospice:** Plans A-G, M and N – Pay 100% of the Part A hospice copayment. Plans K and L – Pay the percentage shown of the Part A hospice copayment.
- **Part B deductible:** Plans C and F – Pay 100% of the annual Part B deductible ($183.00 in 2017).
- **Part B excess charges:** Plans F and G – Pay 100% of the Part B excess charges.
- **Emergency foreign travel:** Plans C-G, M and N – The insured pays a $250 deductible and then 20% of any remaining costs of emergency health care. This benefit is typically limited to a $50,000 lifetime maximum and the first 60 days of each trip.
- **Part B preventive care:** All plans – Pay 100% of the coinsurance for preventive care.

[1] Plan N pays 100% of the Part B coinsurance except for a co-payment of up to $20 for office visits and $50 for emergency department visits that do not result in inpatient admission.

Seek Professional Guidance

Professional guidance is strongly recommended when choosing a Medigap insurance policy. Also:

- **Medicare:** www.medicare.gov, or by phone at (800) 633-4227; TTY: (800) 486-2048.
- **State government:** Many states operate a Health Insurance Assistance Program, designed to provide information and assistance. Otherwise, the local state insurance department will often provide information about Medigap policies.

Disclosure Notice

The information that follows is intended to serve as a basis for further discussion with your financial, legal, tax and/or accounting advisors. It is not a substitute for competent advice from these advisors. The actual application of some of these concepts may be the practice of law and is the proper responsibility of your attorney. The application of other concepts may require the guidance of a tax or accounting advisor. The company or companies listed below are not authorized to practice law or to provide legal, tax, or accounting advice.

Although great effort has been taken to provide accurate data and explanations, and while the sources are deemed reliable, the information that follows should not be relied upon for preparing tax returns or making investment decisions. This information has neither been audited by nor verified by the company, or companies, listed below and is therefore not guaranteed by them as to its accuracy.

If a numerical analysis is shown, the results are neither guarantees nor projections, and actual results may differ significantly. Any assumptions as to interest rates, rates of return, inflation, or other values are hypothetical and for illustrative purposes only. Rates of return shown are not indicative of any particular investment, and will vary over time. Any reference to past performance is not indicative of future results and should not be taken as a guaranteed projection of actual returns from any recommended investment.

John L. Terry, III - National Producer Number # 1265727 CRD # 1972803

NOTE: Grace Global Alliance is a 501(c)3 non-profit ministryfocused on clergy education, with an emphasis on retirement, taxation, law, leadership and communication. Insurance services to ministers and churches are offered through independent agents of Ministry Benefit Advisors (www.ministrybenefit.com). Investment advisory services to ministers and churches are offered by investment advisor representatives of Ministry Benefit Investments, a SEC-registered investment advisory firm (www.ministrybenefitinvestment.com). Registration as an investment advisor does not constitute an endorsement of the firm by securities regulators nor does it indicate that the advisor has attained a particular level of skill or ability. Ministry Benefit Advisors and Ministry Benefit Investments are affiliated companies.

Disclosures: Presenter is not affiliated or employed by the federal or state government, public assistance program, Social Security Administration or any government or regulatory agency.