THE FOLLOWING UPDATES IRA INFORMATION ON PAGE 43 OF THE Life Insurance MANUAL

■ **Traditional Individual Retirement Account (IRA) – is an example of a tax-qualified retirement plan and has the following key characteristics:**

- Due to the Secure Act, there is no longer a limiting age for contributions.
- Contributions made to the plan in **cash** (checks, money orders, cash, etc.) **are tax deductible**.
- The 2022 limit per year per individual is $6,000 for those age 49 years old and younger, and $7,000 for those age 50 and older (also, you can't put in more than you earn).
- Distributions (income) from the IRA must be taken by age 72.
- **ALL WITHDRAWALS** are TAXED. If younger than 59½, there is also a 10% tax penalty.

See Health Updates beginning on next page.

THE FOLLOWING UPDATES FSA TAX INFORMATION ON PAGE 13 OF THE ACCIDENT & HEALTH MANUAL:

Programs Using Pretax Dollars to Pay Out-of-Pocket Expenses

6) Flexible Spending Account (FSA) – Also called a *flex plan* or a *cafeteria plan* (IRS Sec. 125), a **flexible spending account (FSA) is an employer-sponsored benefit** that allows an employee to pay for eligible medical expenses on a pretax basis (similar arrangements are available for dependent and child-care expenses). Employees expecting to incur medical expenses that won't be reimbursed by the regular health insurance plan can take advantage of an employer-sponsored FSA if one is offered.

An FSA saves individuals money by reducing their income taxes. The contributions you make to an FSA are deducted from pay *before* federal, state, and Social Security taxes are calculated and are never reported to the IRS. Taxable income is decreased, and spendable income is increased. The limit on **health care** FSA contributions per individual is **$2,850 per year** (2022). Some businesses offer dependent care FSAs for **dependent expenses**, which has an IRS **2021 per household limit of $5,700** (2022) per year.

FSAs are notorious for their **"use it or lose"** rule, which means that if money is left in an FSA account, it *cannot* be rolled over for reimbursement use in the next calendar year (a 2.5-month grace period began in 2012). Today, **employers <u>can amend</u> their plan** to allow a carryover from one year to the next of **up to a maximum of $570** (this alters the previous FSA "use it or lose it" rule). If allowed by the plan through amendment, this carryover does not impact the indexed $2,750 pretax contribution an employee plan participant can make for the tax year. If the plan is not amended, a carryover is not allowed.

At the beginning of the plan year (which usually starts January 1st), your ***employer asks you how much money you want to contribute for the year (there are limits)***. You have ***only one opportunity a year to enroll*** unless you have a qualified *family status change*, such as marriage, birth, divorce, or loss of a spouse's insurance coverage. The ***amount you designate for the year is taken out of your paycheck in equal installments each pay period and placed in a special account by your employer.***

As you incur medical expenses that are not fully covered by your insurance, you submit a copy of the Explanation of Benefits (EOB) or the provider's invoice and proof of payment to the plan administrator, who will then issue a reimbursement check. Any expense that is considered a deductible medical expense by the Internal Revenue Service and is not reimbursed through your insurance plan can be reimbursed through the FSA.

THE FOLLOWING UPDATES HSA LIMITS ON PAGE 14 OF THE ACCIDENT & HEALTH MANUAL:

7) High-Deductible Health Plan (HDHP) and Related Health Savings Accounts (HSAs) –

HSAs can be used with health plans with decreased minimum deductibles, and ***a much higher percentage of the population is eligible to enroll in them*** compared to the predecessors of these types of accounts, such as MSAs (medical savings accounts). Here are some of the key characteristics when a HDHP is matched up with an HSA:

Employers of all sizes can offer an HSA account and insurance plan to employees *and* individuals who qualify medically and financially can obtain an HSA as well.

The concept is that ***a tax-favored savings account is combined with a qualifying high-deductible health plan*** (HDHP). HSAs enable small employers and individuals and their families to take control of their own health care decisions.

One of the key aspects of HSAs is a system that is responsive primarily to individual consumers rather than to third-party payers. The consumer is required to first have a high-deductible health insurance plan that qualifies to be partnered with an HSA. These plans are available through various insurance companies, depending upon geographic area.

Currently (2021), the plans are all similar in the fact that HDHPs **have deductibles that range** from **$1,400 and $7,050** for singles, and from **$2,800** and **$14,100** for families. Once an HDHP insurance policy has become effective, the funding of the HSA may commence. Annual contribution levels for 2020 HSAs are as follows:

- **Maximum annual** HSA contribution for an **eligible individual with self-only coverage is $3,650**.
- **For family coverage, the maximum HSA contribution is $7,300.** These limit ranges and contribution levels can change from year to year, so consult your carrier or account for specific details for any given tax year.
- In addition, there is a ***catch-up*** contribution provision for HSA account holders **aged 55 and older of $1,000 per year (added to single or family limits, above)**.

HSAs allow the legal avoidance of federal income tax by depositing 100% of the health plan's deductible (subject to the annual contribution limit) into the HSA. Whatever is deposited into an HSA during the tax year allows a federal income tax deduction even if the taxpayer takes the standard deduction and does not itemize deductions. If your employer makes an HSA contribution for you, it is *excluded* from income and not subject to any income tax or FICA. Therefore, **whether the contribution is made by an employer or by the employee, it still results in a reduction of federal income tax due for the year.** Most states also allow you to take a state income tax deduction for HSA contributions. In addition, ***unused balances*** **roll over** into the next year for eligible medical expenses.

If an HSA holder is **under age 65** and uses the money accumulated for ***non-health*** **expenses, the**

benefits are taxable plus a 20% penalty (there are some exceptions such as death or disability). Any benefits withdrawn **after age 65** are **taxed without penalty**.

THE FOLLOWING UPDATES MEDICARE LIMITS ON PAGE 31-34 OF THE ACCIDENT & HEALTH MANUAL:

SECTION III) SOCIAL INSURANCE

(6% of Content – 3 Questions)

Medicare is a federally based medical expense program for people who are **65 or older** regardless of whether or not they are currently employed. In addition, people ***under* 65** can qualify for Medicare if:

- they are suffering end-stage kidney (renal) failure, or
- they have been collecting Social Security or Railroad disability benefits for at least two years,
- they have Lou Gehrig's disease (ALS – amyotrophic lateral sclerosis)

OVERVIEW: Medicare has **four parts:**

PART A – Hospital care (automatic, premium free)

PART B – **Physician and supplemental coverage** (insured must pay a monthly premium; this is optional coverage

PART C – **Medicare Advantage** (does not include Parts A and B above)

PART D – **Prescription drugs**

As mentioned earlier, many **private insurers offer Medicare supplements**, commonly known as **Medigap** policies. Enrollment for Medigap policies is **six months** after an individual **first signs up for Part B**. A Medicare-qualified individual ***cannot* purchase a supplemental policy *unless* he or she has enrolled in Part B**, which is optional and requires a premium payment by the insured. ***All* Medigap policies have a 30-day free look period.** (Also refer to **"Medicare Supplements"** in Section I *above* for the *10* standardized supplements offered for sale.)

A) Medicare Parts A, B, C, D

■ **Medicare Part A – Hospital Insurance –** Coverage, with a deductible, is listed below (please note the daily deductible can change annually for inflation, and the following figures are based on 2022 limits). The amount is not important but rather understanding the concept that significant amounts of money can be owed by insureds is the main point. **Part A is considered to be *premium free* if the recipient is fully insured under Social Security (40 quarters) and receiving benefits, while all other parts are optional. This premium free status is enjoyed by about 99% of those participating in the Medicare Part A program.**

Enrollees age 65 and over who have **fewer than 40 quarters of coverage** and certain persons with disabilities **pay a monthly premium** in order to receive coverage under Part A. Individuals with 30–39 quarters of coverage may buy into Part A at a reduced monthly premium rate, which is $259.00 while those with fewer than 30 quarters of coverage pay the **full premium of $499.00 a month**.

The Coverages of Part A include:

- **Hospital care –** All covered services for 60 days **except in-hospital deductible charge ($1,556) due for each benefit period**. After 60 and up to 90 days, the **daily deductible** amount is $389, and for the 91st day and thereafter, $778 is charged daily to the insured (up to coverage day 150, when all Medicare Part A lifetime days are exhausted and a supplement covers hospital charges after this limit is reached).
- **Inpatient skilled nursing** facility care as medically necessary **– All covered expenses first 20 days**, then next 80 days with a $194.50 daily deductible. (After 100 days, Medicare no longer pays for nursing home expenses). This does ***not*** cover custodial or long-term care.
- **Home health visits for services such as** intermittent skilled nursing care, physical therapy, speech-language pathology services, or continued occupational services.
- **Hospice care – Which is making terminally ill patients more comfortable in the last few days of life with pain medications, is also covered**.

■ **Medicare Part B – Medical Insurance** – Part B helps to pay **physician's bills, home health service, psychiatric care, and other medical and health services**. **A deductible is paid ($233 for 2022), and then cost is split 80%/20%; that 20% does not end (expenses that are *medically necessary*). Part B will also cover *preventive services* (e.g., flu prevention)**. Unlike Part A, **Part B coverage is not mandatory**, although most people covered under Plan A also have Part B coverage (an additional premium is charged by the government). The insured must have Part A to receive Part B coverage.

The insured under Part A must opt for Part B, which requires the insured to pay a monthly premium, to be eligible to purchase a Medicare supplement policy. In 2022, this monthly amount equals $170.10 for the lowest income tier (at or below $91,000 for singles and at or below $182,000 for married filing jointly.

Part B covers certain drugs, such as injections you get in a doctor's office, certain oral cancer drugs, and drugs used with some types of durable medical equipment, such as a nebulizer or external infusion pump. Under very limited circumstances, Part B covers certain drugs given in a hospital outpatient setting. The insured pays 20% of the Medicare-approved amount for these covered drugs. Part B also covers flu and pneumococcal shots. **Generally, Medicare drug plans cover other vaccines, such as the shingles vaccine, needed to prevent illness.**

There are five tiers of premium cost based on the insured's income level. The **lowest tier is for less than $91,000 income** (the cost cited in the previous paragraph) while the highest tier level is $500,000, at which level the monthly cost of Part B is $578.93. For married filing jointly taxpayers, double the income (up to a limit of greater than or equal to $750,000) levels shown above.

■ **Medicare Part C –** If a senior has Medicare Parts A and B, he or she can join a **Medicare Advantage plan**. The senior insured who selects a Part C plan is covered through a local geographic provider network (HMO or PPO typically) that has been approved by Medicare.

With the Part C choice, **a Medigap policy is not used**, and it is illegal to try to sell a Medigap policy to an insured in a Medicare Advantage plan. **Medicare Advantage plans charge a monthly fee by which all normal Part A and Part B benefits are covered without requiring deductibles or copayments. Medicare Advantage plans include the following:**

- Medicare managed care plans,
- Medicare preferred provider organization (PPO) plans,
- Medicare private fee-for-service plans, and
- Medicare specialty plans.

Seniors who decide to join a Medicare Advantage plan will use the health card they get from their Medicare Advantage plan provider for their health care. **Most Advantage plans also offer Medicare Part D**, but if they do not, Part D is also available to the insured opting for a Part C plan.

■ **Medicare Part D –** Begun on January 1, 2006, this is the **federal government's plan to provide prescription drug benefits** to those who qualify for either Medicare Part A (hospital insurance) and/or Part B (medical insurance). ***Every eligible senior citizen must choose from privately run drug plans, each with its own list of covered drugs, designed to fit individual budgets and prescription drug needs.*** **Each plan can vary in cost and drugs covered.**

Medicare drug plans are **offered by insurance companies** and other private companies approved by Medicare. **Coverage is available two ways:**

1) Medicare prescription drug plans (sometimes called *PDPs*) add prescription drug coverage to original Medicare, some Medicare private fee-for-service (PFFS) plans, some Medicare Cost plans, and Medicare medical savings account (MSA) plans.

2) Medicare Advantage plans (such as HMOs or PPOs) or other Medicare health plans offer prescription drug coverage. You generally get all of your Medicare Part A (hospital insurance), Medicare Part B (medical insurance), and Part D through these plans. Medicare Advantage plans with prescription drug coverage are sometimes called *MA-PDs*.

■ **Monthly premium.** The **premium for Part D is paid in addition to the Part B premium**. In a Medicare Advantage plan (such as an HMO or PPO) or a Medicare Cost plan that includes Medicare drug coverage, the monthly premium may include an amount for drug coverage.

Higher-income insureds pay a higher monthly premium based on their income. Extra charges above the premium cost are applied starting when modified adjusted gross income is more than $91,000 (individuals and married individuals filing separately) or $182,000 (married individuals filing jointly). **This is called the income-related monthly adjustment amount (IRMAA)**, which ranges from about 40 cents to more than two dollars per day, based on income.

■ **Coverage.** Medicare **drug plans cover generic and brand-name drugs**. All plans must cover the same categories of drugs, but generally plans can choose which specific drugs are covered in each drug category.

■ **Cost. Plans** have different monthly premiums. The **amount paid for each prescription depends on which plan the insured chooses.** Recipients with limited income and resources may qualify for Extra Help from Medicare when paying for drug plan costs.

Copayments or coinsurance for prescriptions **is paid after the insured has met the deductible**. The insured pays his or her share, and the plan pays its share for covered drugs. Usually, the amount paid for a covered prescription is for a one-month supply of a drug. However, the insured may request less than a one-month supply for most types of drugs.

Each plan may cover different drugs, so there's no single **formulary (drug list)** that fits all plans. **All Medicare drug plans must make sure the people in their plan can get medically necessary drugs to treat their conditions.**

The ***coverage gap*** **(known as the *donut hole***) is **reached after the insured has spent a certain amount of money** for covered drugs. Once in the coverage gap, the insured pays more out-of-pocket costs for drugs up to a specified limit. Not everyone will reach the coverage gap. Costs such as the yearly deductible, coinsurance or copayments, and amounts paid in the coverage gap all count toward this out-of-pocket limit. The amount the insured is required to pay in the coverage gap will shrink by the year 2022 to a maximum of 25% of the cost of the drugs.

Once the insured spends $7,050 out of pocket in 2022, he or she is out of the coverage gap of Medicare prescription drug coverage. Once out of the coverage gap, the **insured automatically gets *catastrophic coverage***, which assures the insured is **required to pay only a small coinsurance amount or copayment for covered drugs for the rest of the year.**