Protective

MEDICARE MADE SIMPLE

Guide for financial professionals

Protective refers to Protective Life Insurance Company and Protective Life and Annuity Insurance Company.
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Are you ready to help seniors navigate Medicare?

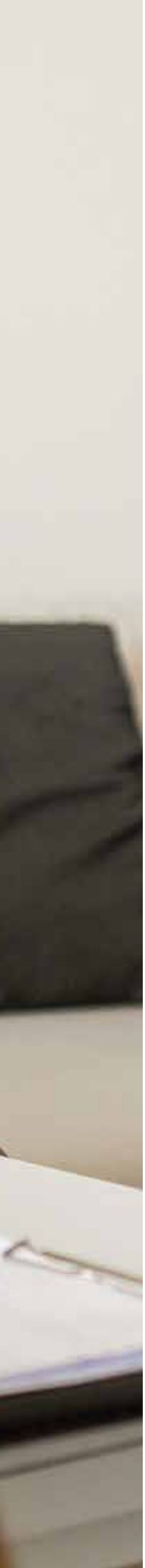
For those nearing 65, there are critical Medicare decisions ahead. It's arguably one of the biggest retirement decisions that lacks the most support for seniors today. They may not know that even small mistakes could be irreversible and costly — and that choosing a plan is highly individual, based solely on their own needs. Many feel overwhelmed and just don't know where to begin. This is why we created the Medicare Made Simple program.

Protective

Medicare Made Simple from Protective

With our simple, repeatable approach and turn-key resources, you can feel confident helping people prepare for key Medicare decisions. This guide will help you get started.

In this guide you'll find the following information:



The complexity of Medicare

A brief history

Medicare then

Before 1965, it was extremely hard for those over age 65 to obtain private health insurance, leaving many seniors vulnerable to financial hardship if they faced large hospital or medical expenses.[1] Medicare was created to help ensure seniors had access to health care. However, at the time Medicare was introduced, the average life expectancy was shorter, health care costs were lower and seniors generally used fewer Medicare-covered services.[1]

Medicare now

Today, Medicare remains the federal health insurance program for those who are at least 65 and have paid Medicare payroll taxes for a minimum of 10 years. Persons under age 65 with disabilities and end-stage renal disease (ESRD) can also qualify. But the program has evolved — and so has today's senior population. People are living longer, health care costs are higher and the majority of seniors have at least one chronic health condition. Because of these and other factors, Medicare may no longer serve as an all-inclusive insurance solution.

Life expectancy almost

80[2]

Health care costs in retirement are

higher

(over $315,000 for a couple)[3]

6 in 10

have at least one chronic condition[4]

[1] "Thirty Years of Medicare: Impact on the Covered Population" Health Care Financial Review, 1996 Winter.

[2] U.S. Life Expectancy 1950-2022 | MacroTrends.

[3] "Health Care Averages $67,000 for Retirees — With Medicare", Money, 2022 https://money.com/health-care-expenses-retirement-average-67k-medicare/.

[4] Centers for Disease Control and Prevention. (n.d.). About Chronic Diseases. Retrieved on December 1, 2022 from cdc.gov/chronicdisease/about/index.htm.

Common mistakes and consequences

While working, seniors often get help from the Human Resources department to inform their health care coverage choices. But as retirement nears, they're left to self-study and digest a 130-page Medicare booklet on their own, opening the door to potential missteps during the Medicare enrollment process.

Understanding common mistakes and their potential consequences will help you prepare those nearing age 65 for key Medicare decisions — and help them avoid costly mistakes that could impact their ability to pay for or receive the health care they need. You can help them avoid:

Late enrollment penalties that permanently increase premiums for Medicare Parts B and D.

The responsibility of paying for unexpected health expenses — or not having a primary payer at all — due to incorrect assumptions being made about how their current coverage will work after age 65.

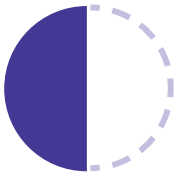
Loss of Guaranteed Issue Right for a Medicare Supplement because of improperly timed Part B enrollment, which could make it difficult for people with preexisting medical conditions to qualify due to underwriting restrictions.

Long delays in coverage if the Initial Enrollment Period is missed and they are not eligible for a special enrollment period.

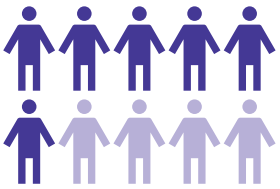
Big problem, big opportunity

With so many people turning 65 every day, and more people working into retirement, the likelihood of mistakes only goes up. This is a great opportunity for you to help seniors and show your value, since many don't understand Medicare and how they'll plan for future health care costs in general.

10,000
Boomers are turning 65 every day until the year 2030.[5]



Almost half
of baby boomers expect to work past age 70 or do not plan to retire at all.[6]



6 in 10
people are terrified of what a global health crisis might do to their retirement plans.[7]

60%
know little about Medicare.[8]

$6.4 billion
in Medicare enrollment mistakes made annually.[9]

A discussion about Medicare is a great opportunity to open other important conversations with seniors and growth opportunities for your business. You don't have to be a Medicare expert to help get them started on the right path. All you need are a few easy-to-understand concepts that address the most common and potentially risky situations.

Now that we understand how Medicare became complicated, let's take a look at how it can be simplified.

[5] "Cost of Care Survey" Genworth, 2022, https://www.genworth.com/aging-and-you/finances/cost-of-care.html.

[6] "The number of baby boomers and Generation X who plan to work past age 70—or forever—is stunning", Morningstar, 2022, https://www.morningstar.com/news marketwatch/20221015418/the-number-of-baby-boomers-and-generation-x-who-plan-to-work-past-age-70or-foreveris-stunning.

[7] "2022 Health Care and Long-term Care Consumer Survey" The Harris Poll, 2022.

[8] "The Shocking Things People Don't Know About Medicare... ", 2022 https://www.lifehealth.com/shocking-things-people-dont-know-medicare/ 9 65 Incorporated analysis of a sample of consultation clients and extrapolated out to the newly enrolled Medicare beneficiaries in 2019.

[9] 65 Incorporated analysis of a sample of consultation clients and extrapolated out to the newly enrolled Medicare beneficiaries in 2019.

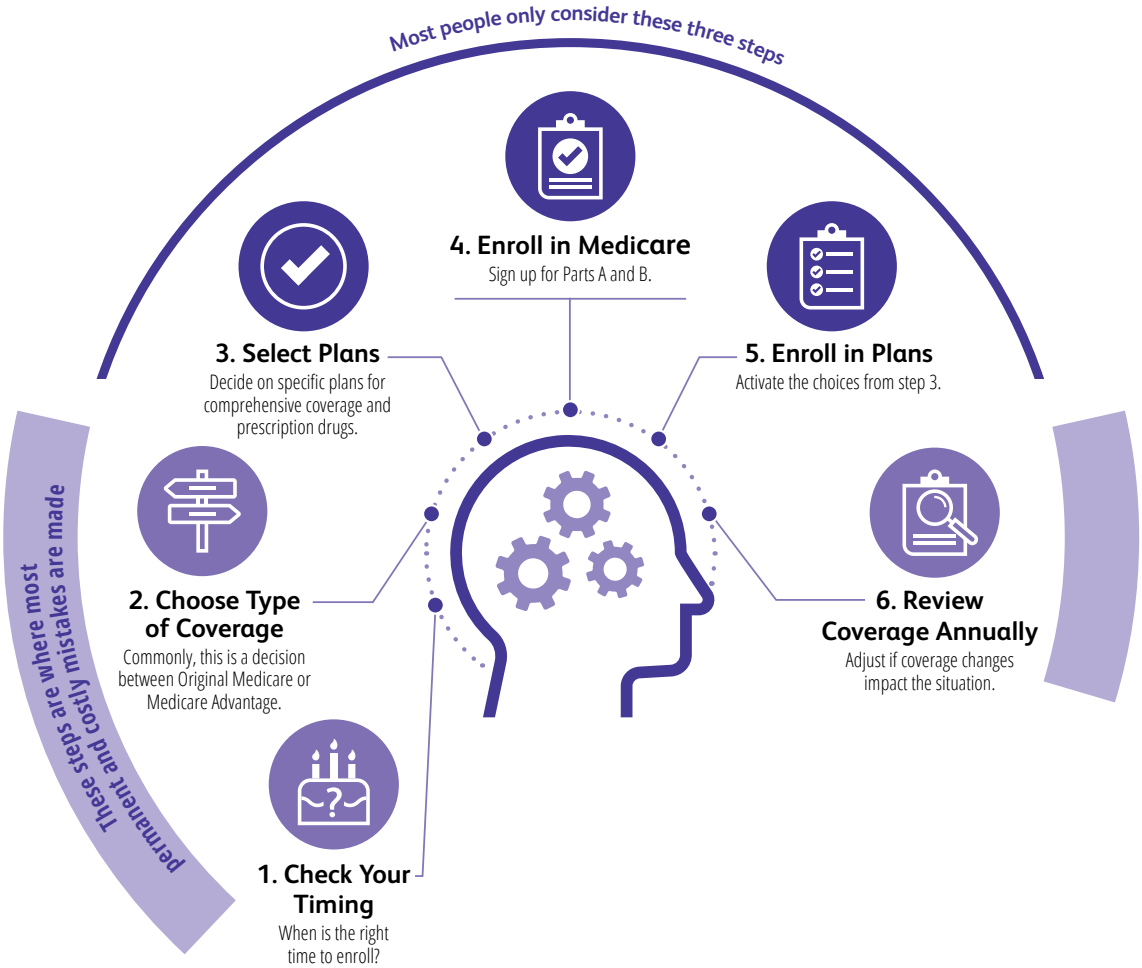
Simplify with a focus on timing and type

The Medicare process

The Medicare decision-making process ideally involves six steps, noted below. Unfortunately, many of the common mistakes mentioned in the previous section occur during the early stages of this process, which many seniors ignore.

Understanding the six steps

Many people jump in by choosing plans without taking time to consider the right timing for Medicare enrollment and the specifications of each type of Medicare. You can help set seniors up for success and make Medicare more manageable by focusing the conversation around the importance of timing and type, so seniors make informed decisions about their coverage.



Medicare enrollment: Timing is (almost) everything

The first decision to be made is when to enroll in Medicare. Many people incorrectly assume that once they turn 65, they must enroll. This is simply not true. For most people, enrolling at age 65 is the right decision; however, there are situations where delaying enrollment may be appropriate and advantageous. Making the right decision is critical to avoid paying for unnecessary coverage, costly penalties or restrictions on coverage that could be permanent.

Typical enrollment windows

Medicare has dozens of enrollment periods, or the times a person can make Medicare decisions. For those just getting into Medicare, the three most common are outlined below:

Initial Enrollment Period (IEP)

Medicare's Initial Enrollment Period is a seven-month period that begins three months before the month of the enrollee's 65th birthday and ends three months after it. There's a unique twist for those who were born on the first of the month. Medicare treats this birthday as though it occurred in the month right before the actual birthday. This means someone born on November 1 has an Initial Enrollment Period that is the same as those who have birthdays in October.

A good rule of thumb: Everyone should pay attention to Medicare during the IEP. They may not need to enroll but there are still important points to know.

Special Enrollment Period (SEP)

Many choose not to enroll in Medicare when first eligible at age 65 because they have coverage through an employer group health plan. This period gives them the chance to enroll in Medicare without penalty or delay.

General Enrollment Period (GEP)

Sometimes, things don't go as planned. People forget, they get misinformation or they miss their chance to enroll in Medicare. The GEP, from January 1 – March 31, is their opportunity to enroll in Medicare. Coverage will begin the month after enrollment,* and they may face late enrollment penalties.

*GEP timing changes as of January 2023.

Key timing considerations

Whether a person needs to enroll in Medicare depends on several different factors. These include, but are not limited to:

- Whether a person is applying for Social Security benefits.
- The type and quality of a person's existing health coverage.
- Whether a person is actively working or retired.
- The size of the employer.
- If a person is making contributions to a Health Savings Account.

Now, let's take a deep dive into some of these factors and examine the potential impact that timing mistakes can make on a retirement plan.

Social Security status:

People can qualify for Social Security benefits at age 62 and many choose to sign up at that time, even if it's not the best financial decision. If they are receiving benefits, at age 65 they will be enrolled automatically in Medicare Part A and Part B and receive their Medicare card in the mail.

Once they turn 65, they must keep Part A, hospital insurance, as this is a condition of receiving Social Security benefits. But, what about Part B, which carries a premium? The need to keep Part B depends on their current health care coverage, such as an employer group plan. If they do not need to enroll in Part B yet, they must suspend it.

For those not receiving Social Security benefits, Medicare enrollment is not automatic. They must take action to assess their situation and enroll if needed.

Incorrectly assuming Medicare enrollment is automatic can cause seniors to miss their Initial Enrollment Period, resulting in **delayed coverage** and possibly a lifetime of late enrollment **penalties**.

Employment size and status:

Many people work past age 65 and have access to employer coverage. In this situation, the need to enroll in Medicare can depend on things like the size of the employer or if a person obtains other coverage, such as a retiree policy or COBRA plan.

If an employer has fewer than 20 workers, Medicare is the primary payer, meaning Medicare must be billed first before another insurance plan may be billed. This presents a problem for a person who chooses to keep their small-group coverage but does not enroll in Medicare. In this situation, the person has no primary payer and has the financial responsibility for medical costs. Seniors should also be careful when obtaining COBRA coverage — this type of coverage is also secondary to Medicare.

If the employer has 20 or more workers, Medicare is considered secondary, and a delayed enrollment may be considered without penalty.

Delaying enrollment due to coverage under another plan considered a secondary payer to Medicare, such as a COBRA continuation plan or an employer plan for fewer than 20 employees, potentially puts people at **risk of being personally responsible for all health care expenses** as a primary payer.

Health Savings Account (HSA) contributions

A HSA is a savings account that can be used in conjunction with a high-deductible health plan that allows users to save money tax-free against medical expenses. Once enrolled in Medicare, an individual is no longer eligible to contribute to an HSA. If enrolling, annual contribution eligibility must be prorated based on when Medicare enrollment occurred during the year. HSA contributions do not affect the ability of the employee's spouse to enroll in Medicare.

Once enrolled in Medicare, distributions from the account can still be used to help cover Medicare expenses. HSA funds may not be used to pay monthly premiums for a Medigap policy.

Continuing to contribute to an HSA while enrolled in Medicare can result in **having to pay back the contributions plus a 6% excise tax.**

Creditable coverage:

A person who has creditable prescription drug coverage through another entity, such as an employer, can delay enrollment in a Medicare drug plan. "Creditable" means that the plan pays at least as much as the standard Part D drug plan. The sponsor of the drug coverage must notify Medicare-eligible policyholders about the creditable status every October.

If delaying Part D enrollment and their plan does not have creditable coverage status, an individual will **face a late enrollment penalty** when signing up for a Medicare Part D drug plan.

Let's look at a sample timing scenario that shows how assumptions about delaying Medicare enrollment are not always correct.

Meet Cynthia

Turned 65 in October

Has coverage through her spouse's employer plan

Believes she can delay Medicare

Cynthia's Medicare timing determination:

Cynthia's spouse works for a company with fewer than 20 employees. As a result, Cynthia needed to find out if she could actually keep this coverage once she turned 65. Medicare rules state that a small employer can require those 65 and older to enroll in Medicare. Cynthia found out that she cannot keep the employer plan when she turns 65 and, as a result, must fully enroll in Medicare.

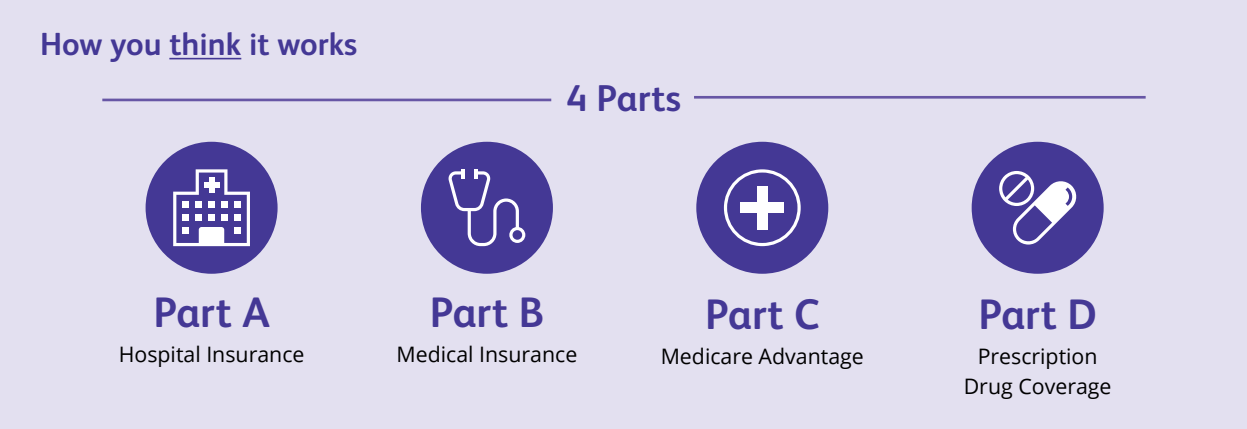
The best approach: Everyone must take a moment during his or her Initial Enrollment Period to figure out when to enroll in Medicare. It is the individual's unique situation that drives the enrollment decision.

Types of Medicare

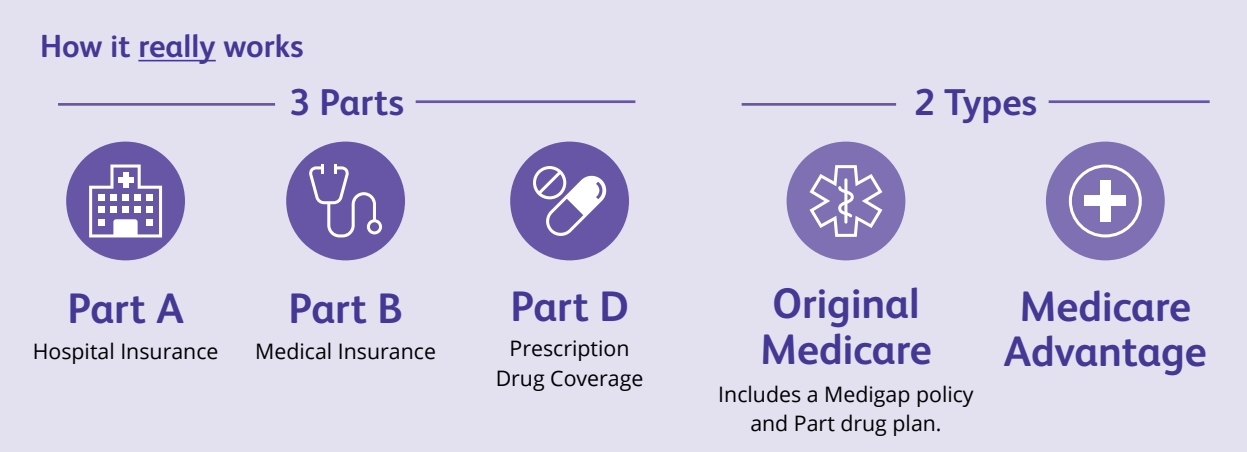
Once a decision has been made on when to enroll, it is time to determine which type of Medicare is appropriate. This is not a decision on specific plans to enroll in, it is a decision on the type — of which the typical options are Original Medicare with a Medigap policy and Part D prescription drug plan, or Medicare Advantage. Before we discuss these two types, it is important to understand how Medicare coverage is structured.

Three parts, two types: A simplified approach to discussing Medicare

You may have heard that Medicare has four parts: Part A hospital insurance, Part B medical insurance, Part C Medicare Advantage Plans and Part D prescription drug coverage. This list often leads to the incorrect belief that you must get each part.



However, that's not quite how the system works. Actually, there are three basic parts with two unique types, or ways to get to those three parts of Medicare.



A closer look at the three parts

Part A — Hospital Insurance:

Part A covers inpatient care in a hospital. It also covers inpatient care in a skilled nursing facility (SNF) and home health care. To qualify for coverage of an SNF stay or home health care, a senior must need skilled services (services that require the skills of a nurse or therapist). Medicare does not cover custodial or long-term care, the services that one might need because of the effects of aging. This could be a personal aide to help with bathing or a move into an assisted living facility for safety reasons. Part A also covers hospice, end-of-life care for the terminally ill. There is no premium for Part A for those who have worked and paid taxes for 10 years or whose spouse has worked.

Part A Out-of-pocket expenses[10]	
Inpatient hospital deductible	$1,600 per benefit period
Inpatient hospital copayment	$400/day from days 61-90 in a benefit period
Hospice care coinsurance	5% for inpatient respite stay or hospice-related drugs
Skilled nursing facility (SNF) copayment	$200/day for days 21-100

Part A out-of-pocket costs are based on a benefit period. A benefit period begins the day of admission to a hospital or SNF. It ends when there have been no hospitalizations or SNF stays for 60 days. Depending on the number of days between admissions, a beneficiary may face more than one deductible per year. A benefit period can extend past 60 days if a person is not out of the hospital for 60 days before being readmitted.

[10] "2023 Original Medicare Costs and Medigap Benefits", 2022, 65 Incorporated.

Part B — Medical Insurance:
Think of this as the outpatient component of Medicare. Part B covers medically necessary services or procedures needed to diagnose or treat a medical condition that can be done in a doctor's office, clinic, a hospital's outpatient department or an urgent care center. In addition to things like diagnostic tests and doctor's visits, Part B also covers preventive services. The most common are flu and pneumonia vaccinations, colonoscopies, mammograms and prostate exams.

Part B Out-of-pocket expenses[10]	
Monthly Premium	$164.00 (higher-income beneficiaries will pay more).
Deductible	The first $226 in claims must be paid by the beneficiary before Medicare begins covering its share.
Coinsurance	Part B covers 80% of the Medicare amount. After meeting the deductible, the beneficiary pays 20%, with no maximum amount.
Part B Excess Charges	Up to 15% of the Medicare-approved amount charged for services by non-participating physicians (who do not accept Medicare assignment) making the beneficiary responsible for these excess charges.

[10] "2023 Original Medicare Costs and Medigap Benefits", 2022, 65 Incorporated.

Part D — Prescription Drug Coverage:
This part of Medicare helps cover the cost of prescribed medications. There are a number of key points of a particular plan to consider. An important consideration that is highly personal is the plan's formulary, which is the list of medications the plan will cover. Medicare sets some standards, but plans determine which medications to cover and the out-of-pocket costs. It is also important to note that drug plans will not cover over-the-counter (OTC) medications, which are those you can buy without a doctor's prescription. Seniors can get prescription drug coverage in a variety of ways — stand-alone Part D drug plans, the most common, and Medicare Advantage plans with prescription drug coverage, known as MA-PD plans.

As for costs, stand-alone drug plans have monthly premiums, starting as low as $7 up to $99* or more, depending on where one lives. The premiums for Medicare Advantage drug coverage are incorporated into the plan's premium. Some plans do not charge for this coverage. Just as with Part B, higher-income seniors are subject to paying more for Part D coverage.

Importance of annual reviews: An annual review of plan coverage during Open Enrollment is important. Premiums, deductibles, cost-sharing and pharmacies can change every year, and cost more than you think. For example, changes in coverage for specific drugs, a plan's formulary, are common and can end up costing hundreds of dollars more from one year to another.

Moving forward with just three parts of Medicare is not the whole story. That's why it's important to know about the two typical types of Medicare — Original Medicare and Medicare Advantage.

* https://www.kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-medicare-prescription-drug-plans-in-2022/

One size does not fit all: Choosing the right type

When it comes to Medicare type, one size does not fit all. Once enrolled, a person has the first two parts of Medicare — Part A and Part B. How they choose to package their coverage from there depends on the type they choose, and choosing the wrong type can put a person in a precarious situation.

Most people enrolling in Medicare choose between two main types: Original Medicare and Medicare Advantage. Let's look at these in more detail and the key considerations for each. Remember that choosing a type of Medicare is a highly personal decision and depends on several factors including existing health conditions, budget and service provider preferences — many of which are discussed in the adjacent table.

CHOOSE YOUR TYPE

Original Medicare Parts A+B+D+Medigap Plan		Medicare Advantage Part C (One package Parts A+B+D)
Administered by the U.S. government.		Administered by a private insurance company.
"Pay now" type of coverage — regular, monthly premiums but then have little, if any, out-of-pocket costs for health care services.		"Pay later" type of coverage — pay little to nothing in monthly premiums, but share in the cost for all services, potentially paying even more if the plan's rules are not followed.
Doctors are in charge. There are no prior authorization requirements for most services.*		The insurance company can require prior authorization for certain services, such as physical therapy, surgery, home health care, etc.
See any provider who accepts Medicare anywhere in the United States.		See any provider within an approved provider network, often regionally based. These networks can change at any time. Care outside of the network may not be covered.
Medicare Part A helps with hospital costs.	**Hospital insurance**	**Medicare Advantage Part C** plans combine hospital costs, doctors and outpatient care in one plan. Part C replaces the coverage provided by Medicare Parts A and B, but you still pay Part B premium.
Medicare Part B helps with doctors, outpatient care and preventive services.	**Medical insurance**	
Medicare Part D helps pay for prescription drugs.	**Prescription drug coverage**	**Part D Prescription Drug Coverage** is available in most Medicare Advantage plans.
Medigap (Medicare Supplement Insurance) covers some costs not covered by Parts A and B.	**Additional coverage**	**Additional Benefits** are often included, such as vision and hearing services.

*Authorization may be necessary for power mobility devices and some procedures, such as nose surgery, that could be considered cosmetic.

Medicare type considerations and impact of mistakes

An important thing to remember, regardless of Medicare type, is that simply enrolling in Parts A, B, or D without any additional coverage may not be enough. Individuals should consider a Medigap policy and Part D drug plan or a Medicare Advantage plan with prescription drug coverage to help keep costs under control, as there are no out-of-pocket maximums for beneficiaries with just Parts A and B.

What if a medical issue, like cancer, developed? If a person did not consider a Medigap policy or a Medicare Advantage plan, they could incur incredible out-of-pocket costs for chemotherapy and other services.

Medicare Advantage plans

These types of plans often boast lower costs up front and package other services together that may appeal to some. Remember that low cost or "no cost" does not mean free — there are still out-of-pocket expenses with these plans, and they can add up quickly if there are medical issues or the plan rules are not properly followed.

Medigap policies

If a person chooses Original Medicare, it is important to consider a Medigap policy, also referred to as Medicare Supplement Insurance, since Parts A and B alone have no out-of-pocket maximum. Medigap policies help cover the "gap" in Medicare Parts A and B coverage. By paying a monthly premium, beneficiaries have few, if any, out-of-pocket costs. These plans are federally standardized with required basic coverage and optional benefits, regardless of carrier. Note that certain states (Massachusetts, Minnesota and Wisconsin) have their own state-specific standardizations.

Guaranteed Issue Right

Guaranteed Issue Right ensures a beneficiary can get a Medigap policy without having to go through medical underwriting. Insurance companies cannot deny coverage or raise premiums based upon an individual's medical history. This right exists for the first six months after Medicare Part B enrollment. After that six months, an individual may not be eligible to get a Medigap policy without answering medical questions.

It's important that seniors understand the rules with Guaranteed Issue Right*, especially since many people mistakenly think they are required to sign up for Parts A and B at age 65. Remember that the timing of enrollment depends on the individual's situation, many of which are discussed in the "Key Timing Considerations" section of this guide. Those who sign up, but do not purchase a supplement because they kept other coverage, are at risk for losing this right after the six month window.

*Extra guarantees are provided in New York, Connecticut, Massachusetts and Maine.

Avoid these common pitfalls when choosing a Medicare type

- Assuming "zero premium" means "free" — out-of-pocket expenses and co-pays can be considerable.
- Believing you can switch from Medicare Advantage to Original Medicare with a Medigap policy at any time — there are two times a year this can happen and medical underwriting can apply.
- Making the same Medicare decisions as a friend or spouse — the coverage could be more costly and not work for their unique situation, and it could be difficult to change.

Let's look at a sample scenario of how choosing the wrong type of Medicare can result in costly and permanent mistakes.

Meet Roy

Age 68

Chose a $0 premium Medicare Advantage plan

Roy's Medicare type mistake:

When Roy enrolled in Medicare, he chose a $0 premium Advantage plan. Three years later, Roy developed a chronic condition that requires regular, and sometimes extensive, medical care. As a result, he now faces many out-of-pocket costs that are adding up fast. He would like to switch to Original Medicare with a Medigap policy so that he can pay a monthly premium and then have no out-of-pocket costs. But, Roy no longer has a Guaranteed Issue Right. With his preexisting medical conditions, he's been denied coverage by three different carriers and is very unlikely to find one that will offer him a policy. Essentially, because he didn't understand the implications of his decision, he now faces thousands more in out-of-pocket costs, is limited to in-network doctors and must receive prior authorization before using certain health care services.

Medicare costs and funding

Medicare costs

Of those on Medicare, 30% have employer sponsored insurance.[11] Misconceptions and a lack of understanding about Medicare can have a serious impact on a person's finances in retirement. With your help, they can understand the potential costs and how to cover them.

Regardless of the type selected, Medicare is not free. Let's look at cost considerations for each. Remember when reviewing these that there is no universal, right choice, as everyone's situation is different. Also keep in mind that Medicare does not cover long-term care expenses, which also should be considered in addition to Medicare costs.

Sample original Medicare monthly costs[11]	
Part A	$0
Part B	$164.90
Medigap policy	$143.60
Standard Part D Plan	$32.74
Monthly + Out-Of-Pocket	$341.24 $226.00
Annual Costs	$4,320.88

There are no additional costs if using Medicare providers.

Sample Medicare Advantage monthly costs[12]	
Part A	$0
Part B	$164.90
Medicare Advantage plan	$21.00
Monthly + Out-Of-Pocket	$185.90 (Deductibles, copays, coinsurance)
Annual Costs	$2,230.80+

This can be thousands when considering copays and additional costs, if prior authorization rules are not followed.

Did you know? Contrary to popular belief, Medicare does not cover long-term care expenses. These types of expenses will be in addition to what a person pays for Medicare.

[11] "Do Most Senior Citizens Have Supplemental Insurance?", Healthcare Management Degree Guide, 2022 https://www.healthcare-management-degree.net/faq/do-most-senior-citizens-have-supplemental-insurance/.

[12] "Medicare isn't enough for retirees — here's how much extra coverage costs in every state, ranked" Business Insider, June 17, 2018.

[13] Source: https://www.kff.org/Medicare/Issue-brief/Medicare-advantage-2021-spotlight-first-look/.

Why some people pay more for Medicare than others: IRMAA and how you can help

What's IRMAA?

IRMAA stands for Income-Related Monthly Adjustment Amount. Higher-income beneficiaries pay more for Part B, medical insurance and Part D, drug coverage, as shown in the table below. The Social Security Administration works with the Internal Revenue Service to identify these beneficiaries, typically looking two years back and adding the amounts below to standard Part B and Part D premiums.

Calculating IRMAA*[10]			
2021 Adjusted Gross Income + Tax-exempt Interest Income		2023 IRMAA	
Single Filers	Individuals Filing Jointly	PART B*	PART D*
≤$97,000	≤$194,000	$0.00	$0.00
>$97,000 to ≤$123,000	>$194,000 to ≤$246,000	$65.90	$12.20
>$123,000 to ≤$153,000	>$246,000 to ≤$306,000	$164.80	$31.50
>$153,000 to ≤$183,000	>$306,000 to ≤$366,000	$263.70	$50.70
>$183,000 to <$500,000	>$366,000 to <$750,000	$366.60	$70.00
≥$500,000	≥$750,000	$395.60	$76.40
Married Individuals Filing Separately		PART B*	PART D*
≤$97,000		$0.00	$0.00
>$97,000 to <$403,000		$326.60	$70.00
≤$403,000		$395.60	$76.40
*These amounts are IN ADDITION to your standard Part B & D premiums.			

How you can help address IRMAA

Considering Roth distributions and other taxable events before they happen can help people prepare for or avoid IRMAA. IRMAA can also be dropped if there has been a life-changing event.

Social Security recognizes the following life-changing events as justification for requesting an adjustment in premiums.

- Work stoppage — this is common for new retirees enrolling in Medicare
- Work reduction
- Marriage
- Divorce or annulment of marriage
- Death of a spouse
- Loss of income-producing property through a natural disaster, arson or criminal theft
- Loss of pension income due to the reduction, reorganization or cessation of an employer's plan
- Employer settlement payment due to bankruptcy or reorganization

Now that we've looked at some potential costs people will pay for Medicare, let's shift to ways in which people can fund their retirement income to offset these costs.

* "2023 IRMAA", 2022, 65 Incorporated.

[10] "2023 Original Medicare Costs and Medigap Benefits", 2022, 65 Incorporated.

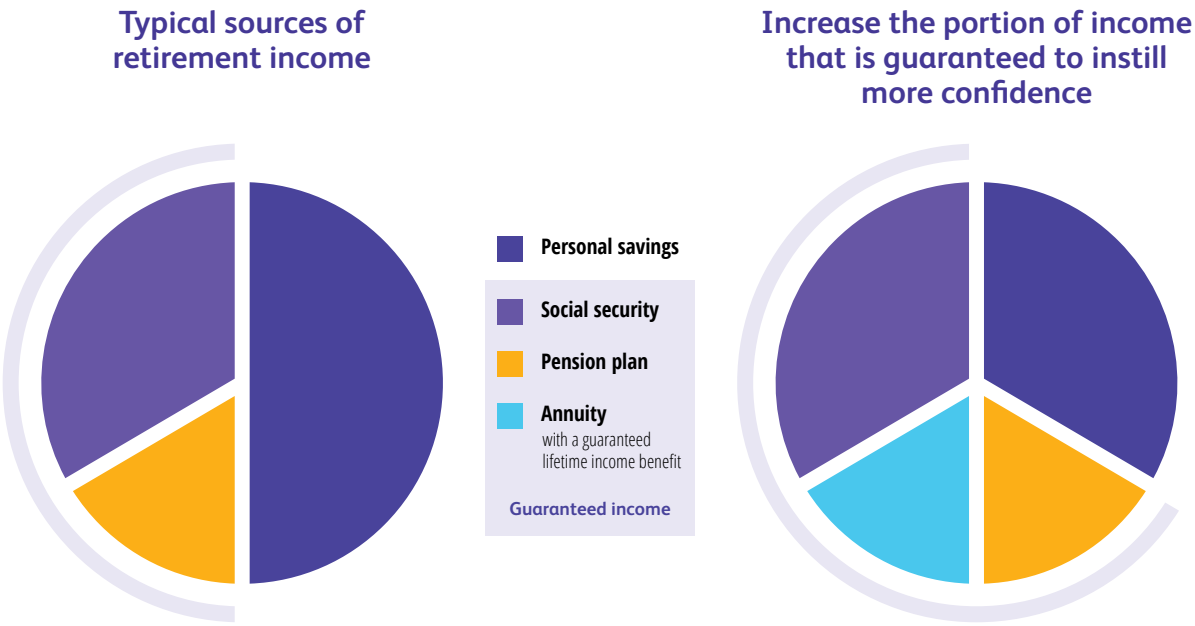
Funding health care costs with guaranteed income

Sources of retirement income typically come from personal savings, Social Security benefits and possibly a pension plan. Social Security benefits and pensions are considered guaranteed sources of income — people can count on the predictability and frequency of them. Other sources, such as income from dividends or the sale of stocks, a part-time job and personal savings are not guaranteed.

People must craft a strategy to make the non-guaranteed part of their income last so market volatility, a chronic illness and other challenges don't put it at risk. If a person relies more on non-guaranteed income sources for expenses in retirement, including health care, the strategy should be evaluated carefully to help increase the likelihood their money will last a lifetime.

Creating a reliable stream of income to cover costs

Converting more income to the guaranteed category fundamentally increases confidence in long-term retirement plans. Why? Because the more income someone can guarantee, the less likely a market drop, sudden cost or change in their health will impact their long-term bottom line of funding a long and lasting retirement.



You can help people build more confidence in their retirement plan using health care and Medicare to transition to a discussion about guaranteeing more of their income. An annuity with a living benefit is one way to support this and helps increase the likelihood that their money will last a lifetime.

Next steps

In this guide, we have shared important information to support you as you prepare those nearing age 65 for key Medicare decisions — and help them avoid costly mistakes that could impact their ability to pay for or receive the health care they need.

Remember, you don't have to be a Medicare expert to help get them started on the right path. Our simple approach helps you steer people away from jumping into specific plan selections. It helps you focus their attention on preparing for key enrollment timing and Medicare type considerations.

Health care is a top concern for people. You can get them started down the correct path with a discussion about Medicare and build their retirement confidence.

Introducing the topic of medicare and health care cost planning

With our Medicare Made Simple prospecting and educational resources, you can start conversations and encourage prospects to:

- Pay attention to Medicare and Open Enrollment.
- Go beyond family or friends when making decisions.
- Consider the impact of IRMAA.
- Address long-term care needs.
- Help establish a budget for Medicare and health care costs in general.

Perhaps the biggest resource we offer is your Protective representative. They are here to support you as you initiate these conversations with turn-key seminars and solutions to address health care costs. Schedule a meeting with your representative to review your book of business and discuss how to:

- Initiate timing/type conversations with your 64-year-olds.
- Initiate health care cost planning needs to pre-retirees (55–64).
- Remind 65+ crowd about their annual review needs.
- Look for an expert partner in your area to whom you can refer clients if needed for specific advice.

Contact your Protective representative and get started today.

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This material was developed by Protective in collaboration with **65 Incorporated**, an industry leader in unbiased Medicare guidance. **65 Incorporated** was co-founded by Diane J. Omdahl and Melinda A. Caughill. Diane is a registered nurse and one of the nation's foremost Medicare experts and Melinda is a noted Medicare speaker. **65 Incorporated** helps consumers and financial professionals with Medicare information and individualized guidance.

To learn more, please visit **65incorporated.com.**

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