VOYAGE BENEFITS

MEDICARE & HEALTH PLAN SOLUTIONS

NAVIGATING MEDICARE

WHO IS VOYAGE BENEFITS?

Voyage Benefits is a Michigan-based insurance agency that serves as a "Medicare concierge."

Our goal is to navigate your transition from employer-sponsored coverage to Medicare with simplicity and ease by:

- Providing education as to when to enroll - setting up timelines
- Guiding you through the enrollment process, when the time is right
- Discussing supplemental plan options, based on individual needs
- Fielding service calls and/or answering benefit questions
- Providing annual coverage reviews

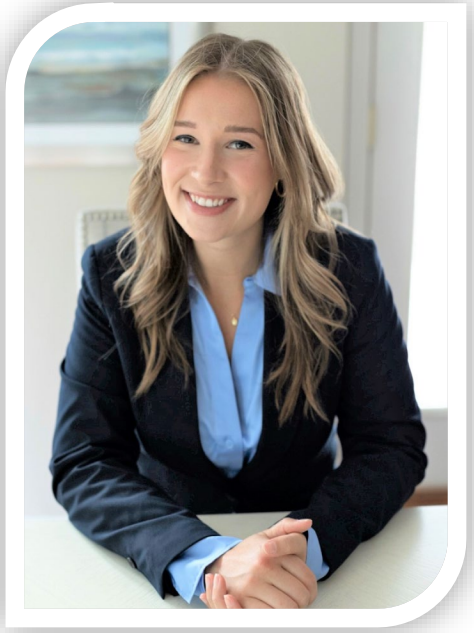
Our services are always complimentary; there is never a fee or obligation to work with our agency. We are compensated by the particular supplemental insurance carriers that you may choose to enroll with.

We take pride in explaining in simple language how your benefits work, so that you feel comfortable and confident with your new Medicare coverage!

OUR TEAM

Kelly Syren
Principal
Licensed Agent

Angie Taylor
Client Service Specialist
Licensed Agent



Lainey Wilson
Client Service Specialist
Administrative

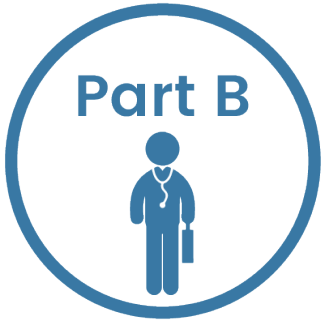
AGENDA

- ORIGINAL MEDICARE - PARTS A & B
  - WHAT IS MEDICARE (and what it is NOT)?
  - WHAT DOES IT COVER?
  - HOW MUCH WILL IT COST?
  - DO I NEED IT?
  - HOW MEDICARE INTERACTS WITH HEALTH SAVINGS ACCOUNTS (H.S.A.)
  - ENROLLMENT PERIODS AND HOW TO ENROLL
- PRESCRIPTION DRUG COVERAGE – PART D
- PRIVATE MEDICARE PLANS – MEDICARE ADVANTAGE PART C / MEDIGAP (SUPPLEMENT)
- INDIVIDUAL COVERAGE OPTIONS (pre-65)

ORIGINAL MEDICARE – PARTS A & B

WHAT IS MEDICARE?

- Federal Health Insurance available to (3) groups of people*:
  - Individuals over the age of 65
  - Individuals under the age of 65 with a qualifying disability
  - Individuals who have been diagnosed with End-Stage Renal Disease (ESRD) or Lou Gehrig's Disease (ALS)
- Consists of:
  - Medicare Part A: **Hospital** Insurance
  - Medicare Part B: **Medical** Insurance
- Medicare is NOT:
  - Free
  - A Family Health Plan
  - Social Security Benefits – Although Medicare may integrate with the Social Security Administration, it is not a financial retirement benefit
  - Medicaid – Provides low-cost healthcare coverage to individuals with limited income and resources. Medicare and Medicaid may work together = "Dual Eligible"



*Must be a U.S. citizen and/or legal resident. Legal residents must live in the US for at least 5 years in a row, including the 5 years just before applying for Medicare.

MEDICARE PART A

HOSPITAL COVERAGE

ORIGINAL MEDICARE – PART A

INPATIENT HOSPITAL BENEFITS

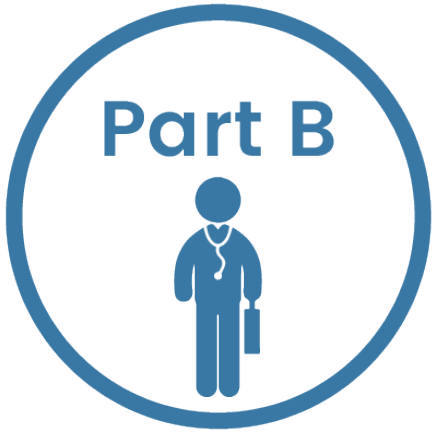
- Hospitalization (90-day Benefit Period)
  - Days 1-60: $1,600 deductible per benefit period*
  - Days 61-90: $400 copay per day
  - Days 90-150: You will have up to 60 "lifetime reserve" days available for $800 copay per day
  - Days 150+: You pay all costs
- Skilled Nursing Facility (100-day Benefit Period)
  - Days 1-20: $0 copay per day *(requires a 3-day prior inpatient hospital stay)*
  - Days 21-100: $200 copay per day
  - Days 100+: You pay all costs
- Home Healthcare
- Hospice
  - For terminally ill patients with life expectancy of <6 months

In most cases, Medicare Part A is awarded to you at no cost if you and/or your spouse have worked at least 10 years (40 quarters) in the U.S.

* A benefit period begins the day you enter a hospital or skilled nursing facility for care. It ends when 60 days have passed since you were discharged. You can experience multiple benefits periods (and multiple deductibles) throughout the year.

MEDICARE PART B

MEDICAL COVERAGE



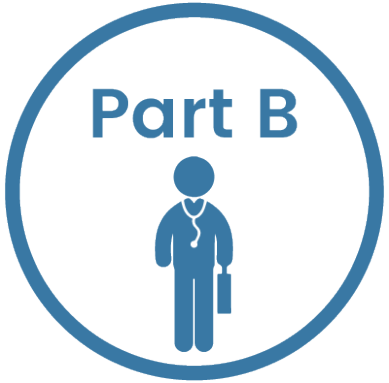
ORIGINAL MEDICARE – PART B

MEDICAL BENEFITS

- Physician Office Visits
- Emergency Room/Urgent Care
- Ambulance Services
- Diagnostic Testing (Labs, X-rays, MRI, CT scans)
- Durable Medical Equipment
- Outpatient Procedures & Services
- Observation

- Preventive Care
  - You will receive a "Welcome to Medicare" exam within your first 12-months of being enrolled in Medicare Part B – covered at 100%
  - Annual Wellness Visits*
  - Certain Immunizations & Screenings
  - Disease Prevention

* Don't confuse an Annual Wellness Visit with a routine "Physical." The Annual Wellness Visit is not a full examination; it simply includes checking routine measurements such as height, weight, blood pressure, and may be with a Nurse Practitioner or Physician's Assistant.



Medicare Part B generally covers **80%** after an annual deductible of **$226.**

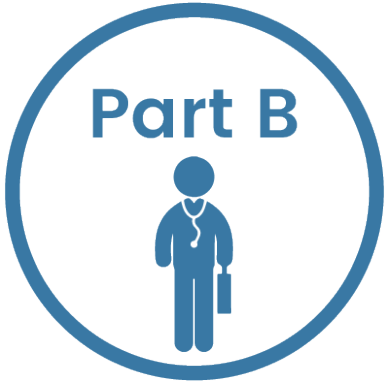
There is no limit or "cap" on what your 20% exposure could be.

ORIGINAL MEDICARE – PART B

2023 MEDICARE PART B PREMIUMS

per person

Filing Individual	Filing Jointly	Married filing Separately	Part B Premium	Part D Premium
$97,000 or less	$194,000 or less	$97,000 or less	$164.90	N/A
$97,000 to $123,000	$194,000 to $246,000	Not applicable	$230.80	$12.20
$123,000 to $153,000	$246,000 to $306,000	Not applicable	$329.70	$31.50
$153,000 to $183,000	$306,000 to $366,000	Not applicable	$428.60	$50.70
$183,000 to $500,000	$366,000 to $750,000	$97,000 to $403,000	$527.50	$70.00
$500,000 or above	$750,000 or above	$403,000 or above	$560.50	$76.40



Premiums are usually deducted from your Social Security benefit payment.

If you are not collecting Social Security benefits, you will be mailed a quarterly invoice or may sign up for Easy Pay (monthly EFT service).

Premiums are based on MAGI from 2 years prior – in 2023, **Medicare will be referencing your income from 2021**
Redetermination of these premium amounts is adjusted by the government every calendar year (or by completing form SSA-44)

ORIGINAL MEDICARE – PART B

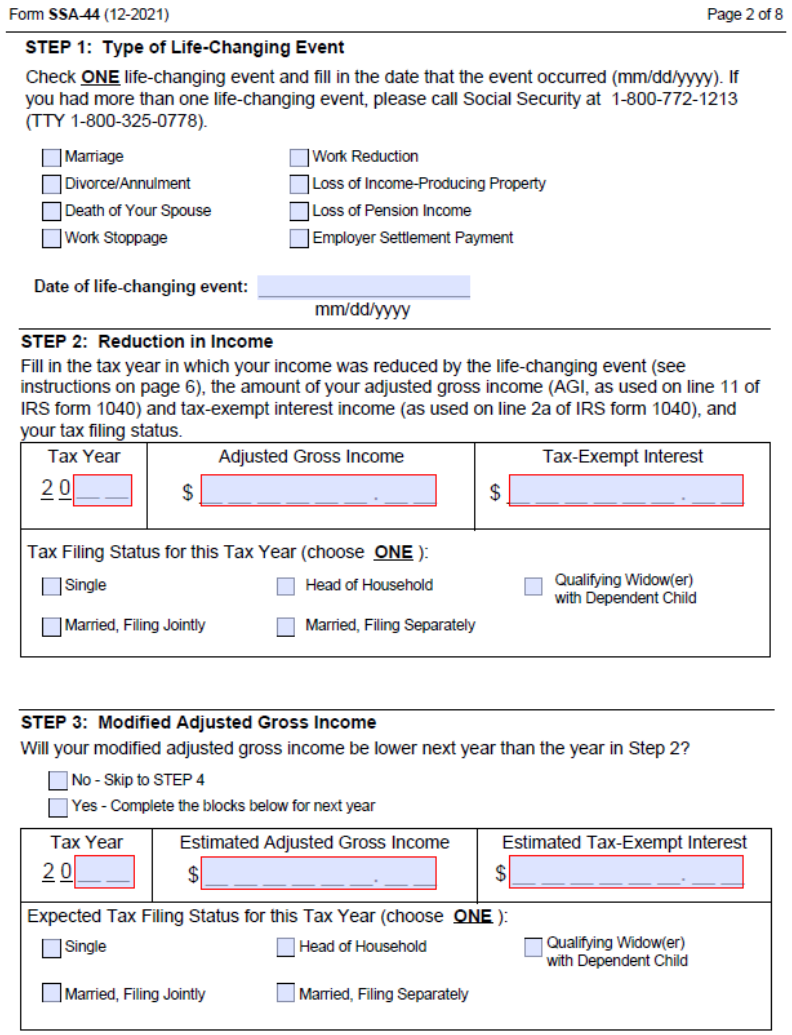
2023 MEDICARE PART B PREMIUMS

WHAT IS IRMAA?

IRMAA stands for
Income-Related Monthly
Adjustment Amount

Medicare determines what your Part B & D premiums will be, based on your Modified Adjusted Gross Income (MAGI) from 2 years prior. Depending on what your taxable income was from that year, you may be charged a "surcharge" or elevated premium until your income is reduced.

If you had, or will be having a major life-changing event (like retirement), resulting in a reduction in income, you may use form SSA-44 to request a redetermination of Medicare Part B & D premiums.



Form **SSA-44** (12-2021) Page 2 of 8

STEP 1: Type of Life-Changing Event

Check **ONE** life-changing event and fill in the date that the event occurred (mm/dd/yyyy). If you had more than one life-changing event, please call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

- ☐ Marriage
- ☐ Divorce/Annulment
- ☐ Death of Your Spouse
- ☐ Work Stoppage
- ☐ Work Reduction
- ☐ Loss of Income-Producing Property
- ☐ Loss of Pension Income
- ☐ Employer Settlement Payment

Date of life-changing event: _____ mm/dd/yyyy

STEP 2: Reduction in Income

Fill in the tax year in which your income was reduced by the life-changing event (see instructions on page 6), the amount of your adjusted gross income (AGI, as used on line 11 of IRS form 1040) and tax-exempt interest income (as used on line 2a of IRS form 1040), and your tax filing status.

Tax Year	Adjusted Gross Income	Tax-Exempt Interest
20__	$	$

Tax Filing Status for this Tax Year (choose **ONE**):

- ☐ Single
- ☐ Head of Household
- ☐ Qualifying Widow(er) with Dependent Child
- ☐ Married, Filing Jointly
- ☐ Married, Filing Separately

STEP 3: Modified Adjusted Gross Income

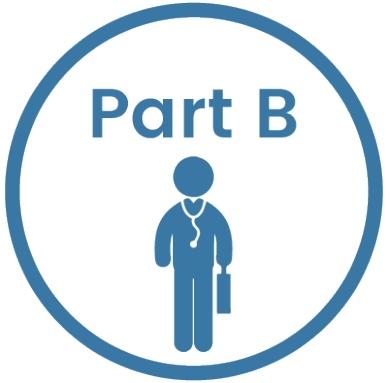
Will your modified adjusted gross income be lower next year than the year in Step 2?

- ☐ No - Skip to STEP 4
- ☐ Yes - Complete the blocks below for next year

Tax Year	Estimated Adjusted Gross Income	Estimated Tax-Exempt Interest
20__	$	$

Expected Tax Filing Status for this Tax Year (choose **ONE**):

- ☐ Single
- ☐ Head of Household
- ☐ Qualifying Widow(er) with Dependent Child
- ☐ Married, Filing Jointly
- ☐ Married, Filing Separately



IRMAA applies to <u>both spouses</u> who are eligible for and enrolled in Medicare Parts B & D, based on their joint taxable income.

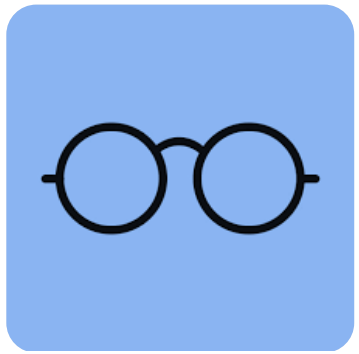
Some examples of taxable income:

- Wages
- 401(k) distributions
- Pension
- Social Security benefits
- Capital gains
- Interest & dividends
- Roth conversions
- Rental property income

ORIGINAL MEDICARE – PARTS A & B

WHAT MEDICARE DOES NOT COVER

Dental

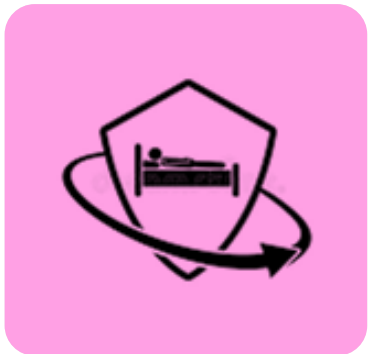


Vision

Hearing

Prescriptions

International Coverage



Long-Term Care

Some of these benefits may be purchased for additional cost,
or may be included in supplemental coverage.

ORIGINAL MEDICARE – DO I NEED IT?

AM I REQUIRED TO ENROLL IN MEDICARE IF I CONTINUE WORKING BEYOND AGE 65?

You may choose to delay enrollment in Medicare A and/or B at age 65 without penalty if:

- You (or your spouse) are actively working, covered under an employer-sponsored benefits plan, and that employer has more than 20 employees.
- You (or your spouse) are disabled, covered under an employer-sponsored benefits plan, and that employer has more than 100 employees.
- You may choose to enroll in Medicare Part A ONLY at age 65, as most people will qualify for premium-free Part A ($0).
  - However, this may affect eligibility to contribute into a Health Savings Account (H.S.A.)
- You may enroll in Medicare A and/or B (later on), based on your retirement date and/or loss of employer-sponsored coverage.

You are strongly encouraged to enroll in Medicare A & B if:

- You (or your spouse) are actively working, covered under an employer-sponsored benefits plan, and that employer has less than 20 employees.
- You (or your spouse) are disabled, covered under an employer-sponsored benefits plan, and that employer has less than 100 employees.
- You are currently covered under COBRA and will be turning 65. Once you turn 65, COBRA will revert to secondary insurance.
- You do not have access to creditable employer-sponsored coverage *(for example, you have individual health coverage through the Health Insurance Marketplace, Christian Health-Sharing plans, Medicaid)*.
- You are eligible for retiree coverage *(through the State of Michigan, Public School System, or from a large employer)*.

ORIGINAL MEDICARE – DO I NEED IT?

HOW MEDICARE WORKS WITH HEALTH SAVINGS ACCOUNTS

Enrolling in Medicare Part A = Ineligible to make H.S.A. contributions

- In order to contribute funds into an H.S.A. (as defined by the IRS), you must solely be insured under a High Deductible Health Plan (HDHP)
- Medicare Part A is not a High Deductible Health Plan (HDHP)

Can I keep funding my H.S.A.?

- YES - If you are actively employed by an employer >20 employees, enrolled in a HDHP, and decline to enroll in both Medicare Parts A & B at age 65.
    - *You may still contribute up to the family maximum per year if you (as the policyholder) are carrying your spouse under your HDHP (as your dependent), and your spouse has Medicare Part A. This is because the H.S.A. account is in YOUR name, not your spouse's.*
- NO - If you choose to enroll in Medicare, you may use the existing funds in your H.S.A., but may not contribute any additional tax-free funds (from any source).

What is the 6-Month Rule?

- If you originally declined to enroll in Medicare at age 65 (because you worked for a large employer and wanted to continue funding your H.S.A.), and are enrolling at a later date, you must cease H.S.A. contributions 6-months in advance of applying for Medicare.
- For people applying later on (post-65), your Medicare Part A effective date will be retroactive 6 months.

*Special Note about H.S.A.'s and Social Security:

If you are collecting Social Security or disability benefits, you are required to be enrolled in Medicare Part A = No H.S.A. contributions into an account held in your name.

ENROLLMENT PERIODS

WHEN SHOULD I SIGN UP?

ENROLLMENT PERIODS

WHEN CAN I SIGN UP?

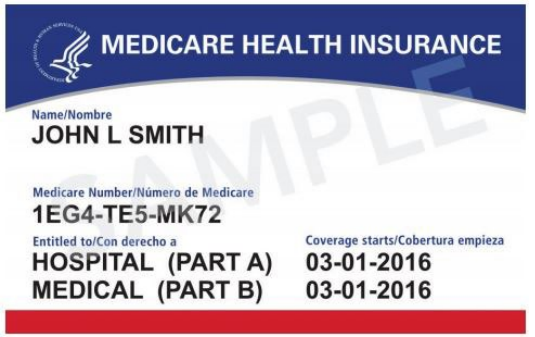
AUTOMATIC ENROLLMENT

Some people will be **automatically** enrolled in Medicare, without having to file an application.

- If you are already collecting Social Security Retirement or RRB benefits, prior to turning 65 – you will be automatically enrolled the 1st of the month in which your birthday falls.
- If you have been collecting Social Security Disability (SSDI) benefits for the last 24 months – you will be automatically enrolled in the 25th month of disability.

If you have been automatically enrolled, and would like to disenroll, you will need to submit a disenrollment form (form CMS-1763), or sign/send back your Medicare card.

The month you turn 65
or after 24 months of SSDI



ENROLLMENT PERIODS

WHEN CAN I SIGN UP?

INITIAL ENROLLMENT PERIOD (IEP)

This is the 7-month window surrounding your 65th birthday.

Timing of when to enroll:

- 3 months prior to your 65th birthday
- The month of your 65th birthday
- 3 months following your 65th birthday

How to enroll:

- Online at www.myssa.gov
- At your local Social Security office
- By phone

You may choose to enroll in:

- Medicare Part A only
- Medicare Part A & Part B

Once you've applied for Medicare Part B, you will begin to be charged the Part B monthly premium.

3 months before you turn 65
Your coverage will begin on the 1st of the month in which your birthday falls

The month you turn 65
Your coverage will begin the 1st of the following month

3 months after you turn 65
Your coverage will begin on the 1st of the following month

ENROLLMENT PERIODS

WHEN CAN I SIGN UP?

SPECIAL ENROLLMENT PERIOD (SEP)

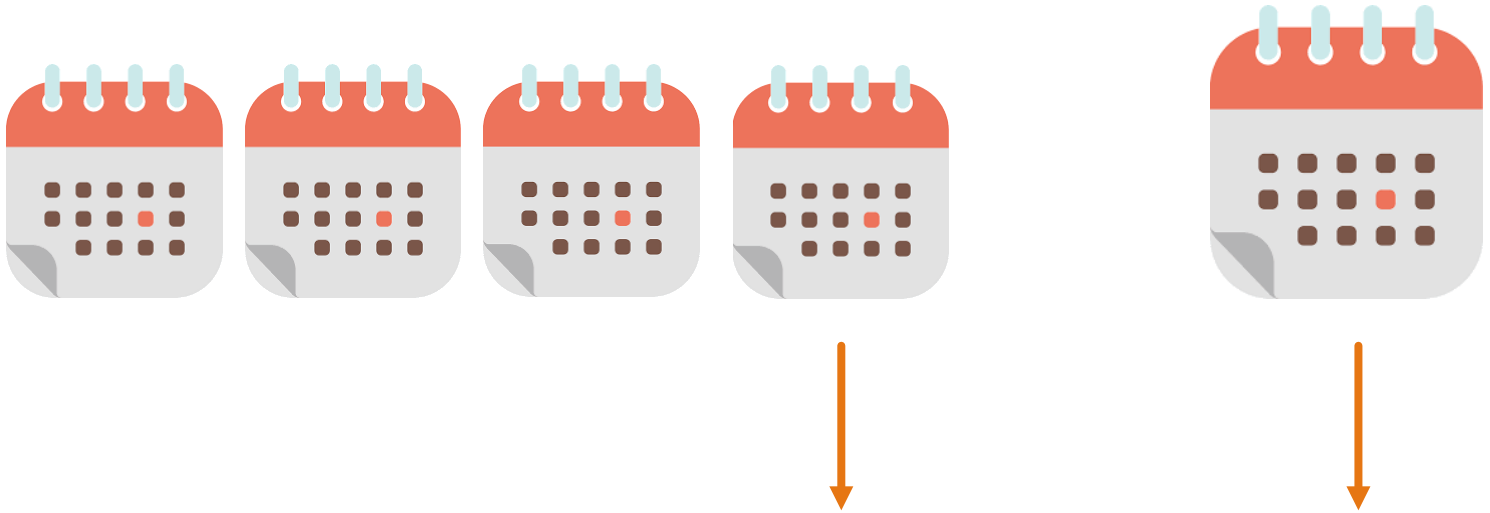
Some people choose to delay enrollment in Medicare at age 65 (IEP) because they are still working, and/or have access to employer-sponsored benefits (**over 20 employees**), and want to keep that coverage.

When retirement or separation of employment occurs (resulting in loss of coverage), you will have an **8-month** period of time to enroll in Medicare.

Your Medicare coverage will begin the month after you lose your employer coverage and/or apply in that 8-month window.

You will not experience a late enrollment penalty as long as you can prove that you maintained continuous employer coverage (form CMS-L564).

Example of a person retiring at age 68



You are retiring and losing employer coverage

You want Medicare to start (1st day of the following month)

ENROLLMENT PERIODS

WHEN CAN I SIGN UP?

SPECIAL ENROLLMENT PERIOD (SEP)

If enrolling under a Special Enrollment Period, you may apply online *(preferred method)*.

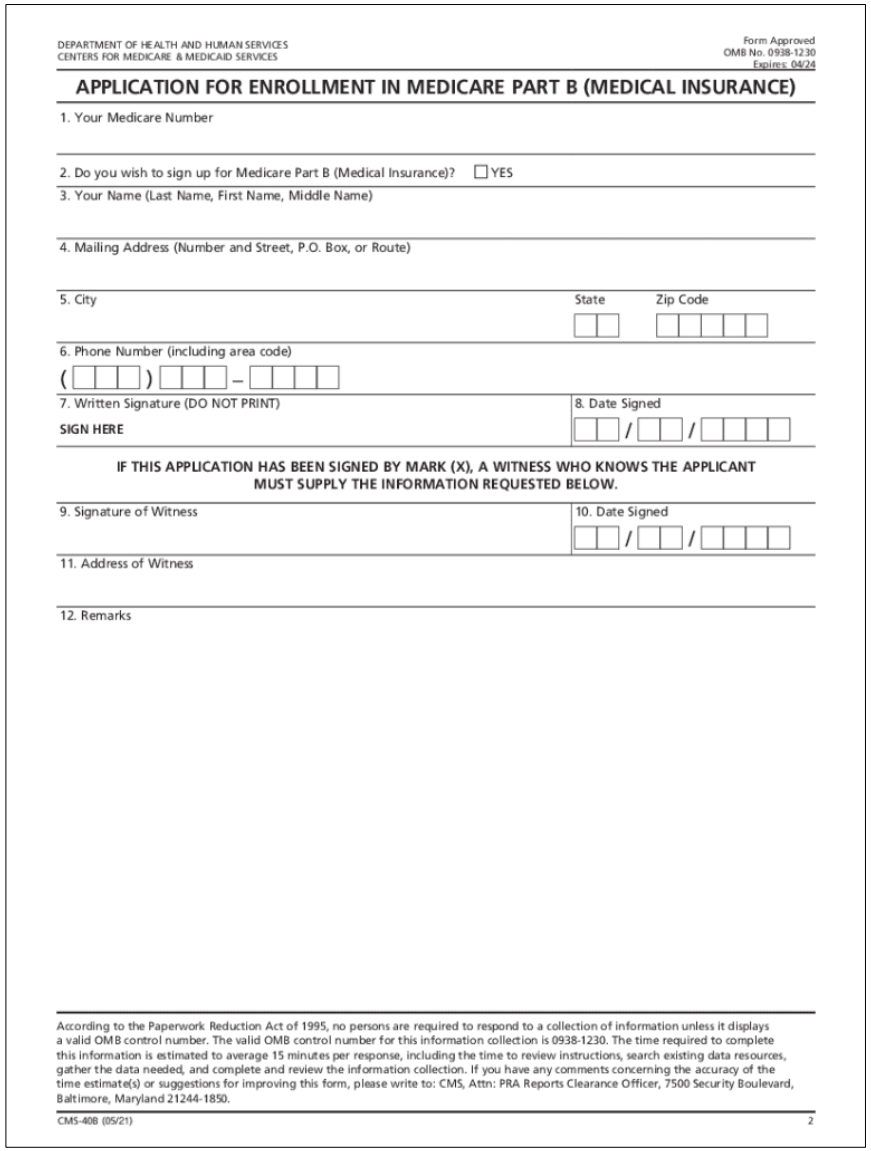
However, you will also need to provide (2) forms for enrollment in Part B:

CMS-40B
Application for Medicare Part B

CMS-L564
Request for Employment Information

You will need to prove that you maintained continuous employer coverage past the age of 65 (to show "where you've been").

These forms may be submitted to your local Social Security office in-person, by fax, or online.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1230
Expires: 04/24

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number

2. Do you wish to sign up for Medicare Part B (Medical Insurance)? ☐ YES

3. Your Name (Last Name, First Name, Middle Name)

4. Mailing Address (Number and Street, P.O. Box, or Route)

5. City | State | Zip Code

6. Phone Number (including area code)
( ) –

7. Written Signature (DO NOT PRINT)
SIGN HERE

8. Date Signed
/ /

IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW.

9. Signature of Witness

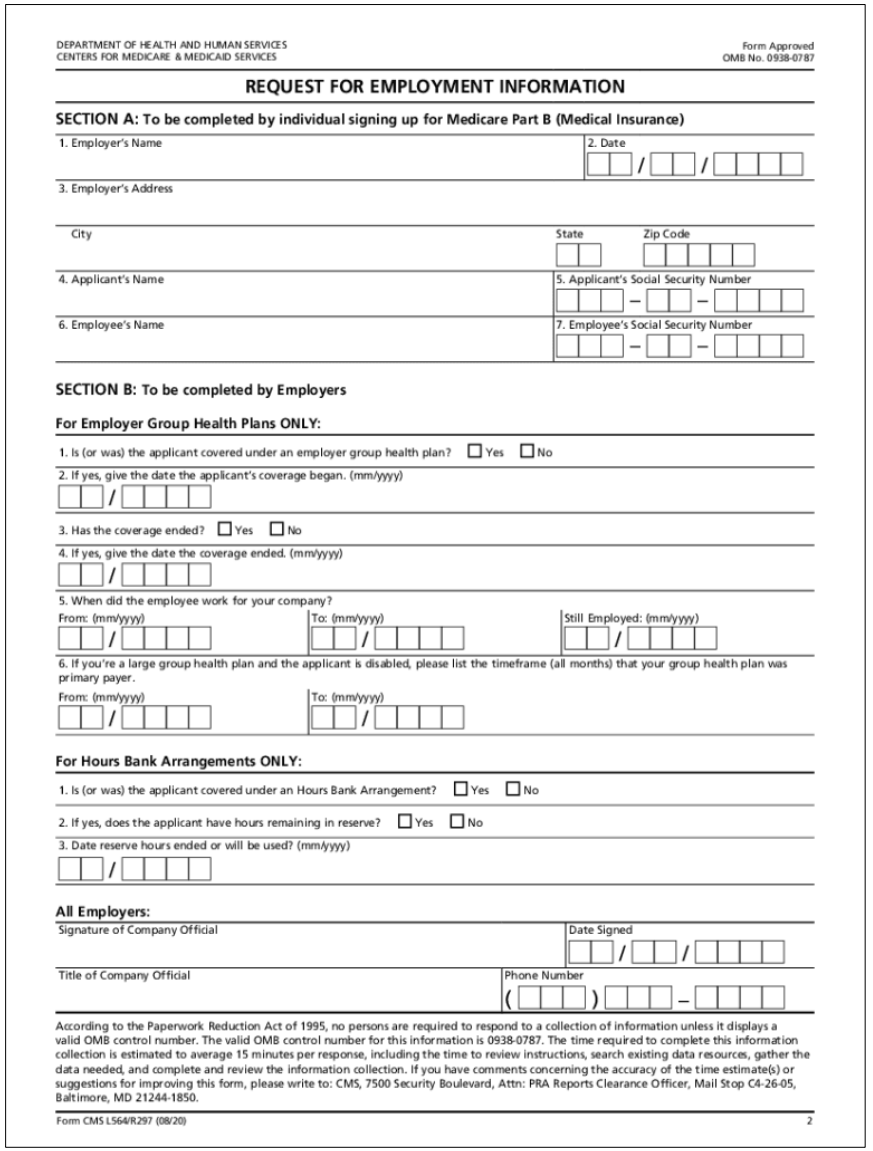
10. Date Signed
/ /

11. Address of Witness

12. Remarks

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1230. The time required to complete this information is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

CMS-40B (05/21) 2



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name | 2. Date
/ /

3. Employer's Address

City | State | Zip Code

4. Applicant's Name | 5. Applicant's Social Security Number
– –

6. Employee's Name | 7. Employee's Social Security Number
– –

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? ☐ Yes ☐ No

2. If yes, give the date the applicant's coverage began. (mm/yyyy)
/

3. Has the coverage ended? ☐ Yes ☐ No

4. If yes, give the date the coverage ended. (mm/yyyy)
/

5. When did the employee work for your company?
From: (mm/yyyy) / | To: (mm/yyyy) / | Still Employed: (mm/yyyy) /

6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.
From: (mm/yyyy) / | To: (mm/yyyy) /

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? ☐ Yes ☐ No

2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ No

3. Date reserve hours ended or will be used? (mm/yyyy)
/

All Employers:

Signature of Company Official | Date Signed
/ /

Title of Company Official | Phone Number
( ) –

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

Form CMS L564/R297 (08/20) 2

ENROLLMENT PERIODS

WHEN CAN I SIGN UP?

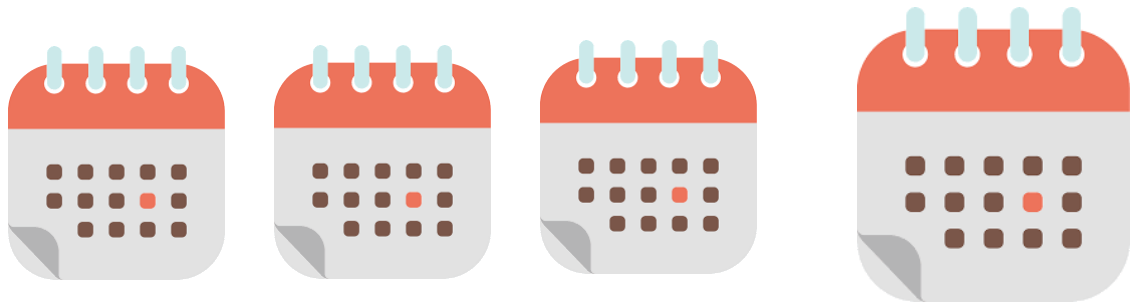
GENERAL ENROLLMENT PERIOD (GEP)

If you failed to enroll surrounding your 65th birthday (IEP), or within 8 months of losing employer coverage (SEP), you will have one final opportunity to enroll in Medicare.

The General Enrollment Period occurs between **January 1 – March 31**

Coverage will begin on the 1st of the following month, and you may be assessed a Late Enrollment Penalty. This is an additional 10% penalty for each 12-month period that you could have enrolled in Medicare, but didn't.

Penalties may apply!



January 1 – March 31

Coverage will begin the 1st of the following month

MEDICARE PART D

PRESCRIPTION COVERAGE

PRESCRIPTION COVERAGE – PART D

4 STAGES OF COVERAGE

DEDUCTIBLE

You will pay 100% of your drug costs until the annual deductible of **$505** is met.

Once the annual deductible is fulfilled, you will move on to the Initial Coverage Stage.

The annual deductible may be waived when filling low-cost, generic drugs. The deductible will apply to more costly, brand-name drugs.

Implementation of the deductible is based on the individual terms of the plan you enroll in.

INITIAL

You may be charged copays (based on drug "tiers") or a percentage of the cost of the drug. The Part D plan determines your copay and will cover the remainder of the cost.

EXAMPLE
Tier 1: $0 copay
Tier 2: $7 copay
Tier 3: $42 copay
Tier 4: $100 copay
Specialty: 33% copay

Once you and your Part D plan have collectively spent $4,660 on covered drugs (called TROOP), you will move into the Coverage Gap Stage

COVERAGE GAP

In this stage, you will pay 25% of the total retail cost of the drug *(set by the pharmacy)*.

Once you (25%), your Part D plan (5%), and manufacturer discounts (70%) have collectively reached $7,400 in covered drug costs (called TROOP), you will move into the Catastrophic Stage

Some people refer to this stage as the "Donut Hole"

If you are taking low-cost, generic drugs, you may not encounter this stage.

CATASTROPHIC

During this phase, the Part D plan pays most of your drug costs for the remainder of the year.

You will pay the greater of either 5% of retail cost or **$10.35** for brand-name or **$4.15** for generic medications.

Per the recently-passed Inflation Reduction Act, this Phase will be eliminated in 2024.

PRESCRIPTION COVERAGE – PART D

SENIOR SAVINGS MODEL FOR DIABETICS

The Part D Senior Savings Model allows participating Part D prescription drug plans to offer a broad set of formulary insulins at a maximum **$35.00** copayment per 30-day supply, throughout the deductible, initial coverage, and coverage gap phases of their Part D drug coverage.

Some of the more-commonly prescribed insulin drugs that are included are:

- Humalog
- Novolog
- Lantus
- Toujeo
- Tresiba
- Levemir
- Soliqua

PRESCRIPTION COVERAGE – PART D

WHAT IS THE LATE ENROLLMENT PENALTY?

You may be subject to paying a late enrollment penalty (LEP) if you do not maintain creditable prescription drug coverage after the age of 65.

How to avoid the penalty:

- Check with your employer to verify that the prescription coverage under your employee benefits plan is creditable *(as good as, or better than Medicare)*
  - If you do not have access to an employer plan with creditable prescription drug coverage, or the employer plan does not include creditable prescription drug coverage, enroll in a Medicare Part D plan at age 65
  - If you do have access to an employer plan with plan with creditable prescription drug coverage, enroll in a Medicare Part D plan within 63-days of losing employer coverage

If you fail to maintain consistent creditable prescription drug coverage past the age of 65 *(either through creditable employer-sponsored coverage or Medicare Part D),* and in the future decide you need prescription coverage, you will be charged an additional 1% for every month you went without creditable drug coverage.

This percentage is multiplied by the national base premium of $32.74 and will be added to your drug plan premium for the **rest of your lifetime**.

EXAMPLE

At the time you turned 65 and/or retired, you were not taking any medications and decided not enroll in a Part D plan.

After 36 months of having not having creditable prescription coverage, you decide to enroll in a Part D plan.

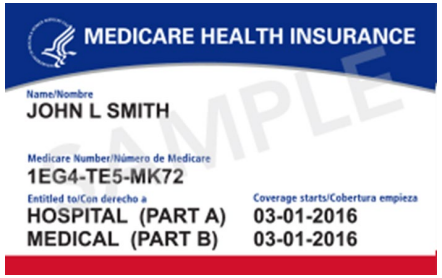
Your penalty will be 36% of $32.74
= $11.80 per month
for the rest of your lifetime

ADDITIONAL COVERAGE

MEDICARE ADVANTAGE & MEDIGAP PLANS

MEDICARE SUPPLEMENTAL COVERAGE – 2 OPTIONS

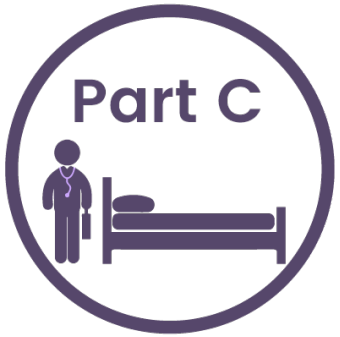
ORIGINAL MEDICARE
You will still need to enroll in Original Medicare, but your benefits will be replaced by a private, managed-care plan



MEDICARE ADVANTAGE
A bundled, all-inclusive plan managed by private insurance companies (Primary).

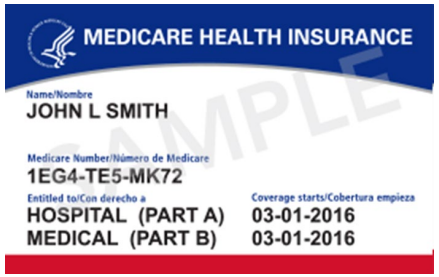
Part C is a <u>REPLACEMENT</u> to Original Medicare, which almost always includes Part D prescription coverage, limited dental, hearing, vision, and wellness benefits.
<u>Network-based coverage (HMO/PPO)</u>

Copays per service apply, up to an annual Out-of-Pocket max



One or the other

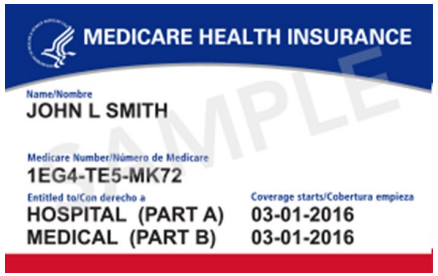
ORIGINAL MEDICARE
Nationwide coverage
Pays 80% after $226 deductible
(Primary)



MEDIGAP/SUPPLEMENT
Pays 20%
(Secondary)

MEDICARE PART D
You must purchase a stand-alone Part D Rx plan

ORIGINAL MEDICARE
Nationwide coverage
Pays 80% after $226 deductible
(Primary)



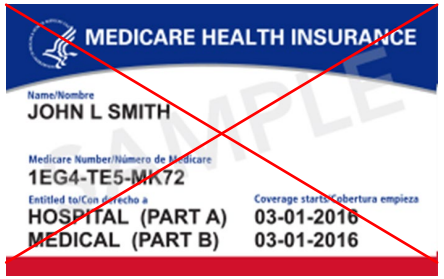
MEDIGAP/SUPPLEMENT
Pays 20%
(Secondary)

MEDICARE PART D
You must purchase a
stand-alone Part D Rx plan

EXAMPLE	MEDIGAP PLAN G (SUPPLEMENT) + PART D PRESCRIPTION PLAN
MEDICARE PART B PREMIUM	**$164.90**
SUPPLEMENTAL PREMIUM	**$130.00**
MEDICARE PART D Rx PREMIUM	**$25.00**
Network Restrictions	No Network *You may use any doctor that accepts Medicare nationwide*
Annual Deductible *(In/Out Network)*	$226
Out-of-Pocket Max *(In/Out Network)*	**$226**
Inpatient Hospitalization	Covered at 100% for up to 150 days, after deductible **Plus an additional 365 days*
Skilled Nursing Facility	Covered at 100% for up to 100 days, after deductible **Requires prior 3-day hospital stay*
Home Health Care	Covered at 100% after deductible
Ambulance Services	Covered at 100% after deductible
Emergency Room Visit	Covered at 100% after deductible
Urgent Care Visit	Covered at 100% after deductible
Physician Office Visits	Covered at 100% after deductible
Preventive Care Services	Covered at 100% after deductible
Diagnostic Services *Includes Testing, Lab Services, X-Rays, Radiology*	Covered at 100% after deductible
Outpatient Surgical/Hospital	Covered at 100% after deductible
Physical & Occupational Therapy	Covered at 100% after deductible
Chemotherapy & Part B Prescription Drugs	Covered at 100% after deductible
Preventive Dental, Hearing & Vision Services	Not Included – may purchase separately
Over-the-Counter Benefit	Not Included
Health Club Membership	Not Included
Prescription Drugs - Initial Phase Applies until retail drug costs reach $4,660	Tier 1: $0 copay or $0/90-day M/O Tier 2: $4 copay or $12/90-day M/O **$505 Annual Rx Deductible (Brand only):** Tier 3: $42 copay or $126/90-day M/O Tier 4: 47% copay retail & 90-day M/O Tier 5 (Specialty): 25% copay

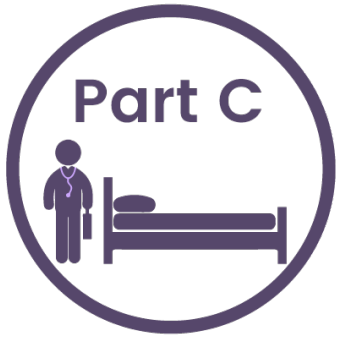
ORIGINAL MEDICARE

You will still need to enroll in Original Medicare, but your benefits will be replaced by a private, managed-care plan



MEDICARE ADVANTAGE

A bundled, all-inclusive plan managed by private insurance companies (Primary). You will no longer need to carry your Medicare card, but rather will use the Plan's ID card.



*Almost always includes Part D prescription coverage, limited dental, hearing, vision, and wellness benefits.
Network-based coverage (HMO/PPO)

Copays per service apply, up to an annual Out-of-Pocket maximum

EXAMPLE	MEDICARE ADVANTAGE PARTS C + D
MEDICARE PART B PREMIUM	**$164.90**
SUPPLEMENTAL PREMIUM	**$0.00**
MEDICARE PART D Rx PREMIUM	
Network Restrictions	HMO or PPO Network *May require prior authorization for out-of-network services*
Annual Deductible *(In/Out Network)*	$0 / $1,500
Out-of-Pocket Max *(In/Out Network)*	**$5,000** / $10,000
Inpatient Hospitalization	$350 copay per day (days 1-5) $0 copay per day (days 6+)
Skilled Nursing Facility	$0 copay per day (days 1-20) $188 copay per day (days 21-100)
Home Health Care	Covered at 100%
Ambulance Services	$275 copay
Emergency Room Visit	$90 copay
Urgent Care Visit	$50 copay
Physician Office Visits	$0 copay for Primary Care visits $45 copay for Specialist visits
Preventive Care Services	Covered at 100%
Diagnostic Services *Includes Testing, Lab Services, X-Rays, Radiology*	$0 - $275 copay
Outpatient Surgical/Hospital	$325 copay
Physical & Occupational Therapy	$40 copay
Chemotherapy & Part B Prescription Drugs	Covered at 80%
Preventive Dental, Hearing & Vision Services	√ Included
Over-the-Counter Benefit	√ Included
Health Club Membership	√ Included
Prescription Drugs - Initial Phase Applies until retail drug costs reach $4,660	Tier 1: $2 copay or $0/90-day M/O Tier 2: $8 copay or $0/90-day M/O Tier 3: $38 copay or $95/90-day M/O Tier 4: 40% copay retail & 90-day M/O Tier 5 (Specialty): 33% copay

EXAMPLE	MEDICARE ADVANTAGE PART C	MEDIGAP PLAN G (SUPPLEMENT) + PART D PRESCRIPTION PLAN
MEDICARE PART B PREMIUM	**$164.90**	**$164.90**
SUPPLEMENTAL PREMIUM	**$0.00**	**$130.00**
MEDICARE PART D Rx PREMIUM		**$25.00**
Network Restrictions	HMO or PPO Network *May require you to use a network provider*	No Network *You may use any provider that accepts Medicare nationwide*
Annual Deductible *(In/Out Network)*	$0 / $1,500	$226
Out-of-Pocket Max *(In/Out Network)*	$5,000 / $10,000	$226
Inpatient Hospitalization	$350 copay per day (days 1-5) $0 copay per day (days 6+)	Covered at 100% for up to 150 days, after deductible **Plus an additional 365 days*
Skilled Nursing Facility	$0 copay per day (days 1-20) $188 copay per day (days 21-100)	Covered at 100% for up to 100 days, after deductible **Requires prior 3-day hospital stay*
Home Health Care	Covered at 100%	Covered at 100% after deductible
Ambulance Services	$275 copay	Covered at 100% after deductible
Emergency Room Visit	$90 copay	Covered at 100% after deductible
Urgent Care Visit	$50 copay	Covered at 100% after deductible
Physician Office Visits	$0 copay for Primary Care visits $45 copay for Specialist visits	Covered at 100% after deductible
Preventive Care Services	Covered at 100%	*Medicare-approved services* covered at 100% after deductible
Diagnostic Services *Includes Testing, Lab Services, X-Rays, Radiology*	$0 - $275 copay	*Medicare-approved services* covered at 100% after deductible
Outpatient Surgical/Hospital	$325 copay	Covered at 100% after deductible
Physical & Occupational Therapy	$40 copay	Covered at 100% after deductible
Chemotherapy & Part B Prescription Drugs	Covered at 80%	Covered at 100% after deductible
Preventive Dental, Hearing & Vision Services	√ Included	Not Included – may purchase separately
Over-the-Counter Benefit	√ Included	Not Included
Health Club Membership	√ Included	Not Included
Prescription Drugs - Initial Phase Applies until retail drug costs reach $4,660	Tier 1: $2 copay or $0/90-day M/O Tier 2: $8 copay or $0/90-day M/O Tier 3: $38 copay or $95/90-day M/O Tier 4: 40% copay retail & 90-day M/O Tier 5 (Specialty): 33% copay	Tier 1: $0 copay or $0/90-day M/O Tier 2: $4 copay or $12/90-day M/O **$505 Annual Rx Deductible (Brand only):** Tier 3: $42 copay or $126/90-day M/O Tier 4: 47% copay retail & 90-day M/O Tier 5 (Specialty): 25% copay

MEDICARE ADVANTAGE VS MEDIGAP

	ADVANTAGE	MEDIGAP
Providers	You may be limited to providers who participate in the Advantage plan's HMO or PPO network	You may receive services from any provider nationwide who accepts Medicare *(no private network)*
Medical Underwriting Pre-Existing Conditions	Never requires medical underwriting, and does not limit pre-existing conditions **You may change your plan each year during the Open Enrollment Period**	May require medical underwriting (and can decline your application) if you do not enroll **within the first 6 months of obtaining Medicare Part B (Golden Ticket)**
Prescriptions	Typically includes Part D prescription coverage	You must purchase a separate Part D drug plan
Cost for Insurance	Lower monthly premiums	Higher monthly premiums
Coverage	Copays and/or coinsurance may apply to particular medical services, accumulating up to the annual out-of-pocket maximum	Covers balances leftover after expenses have been approved and paid by Original Medicare A or B
Primary Payor of Claims	Advantage Plan – Primary	Medicare A or B – Primary Medigap – Secondary

INDIVIDUAL OPTIONS

COVERAGE FOR EARLY RETIREES, SPOUSES & DEPENDENTS UNDER AGE 65

INDIVIDUAL COVERAGE OPTIONS

	COBRA	INDIVIDUAL
Eligibility	COBRA is available to spouses and/or dependents when there is a qualifying event, leading to a loss of active coverage.	Individual health plans are available to spouses and/or dependents when there is a qualifying event, leading to a loss of active coverage, or during each Open Enrollment Period.*
Coverage	Benefits "mirror" the employer-group health plan, and may be subject to change upon the group's annual benefit renewal.	Individual plans are categorized by metal "tiers" with various benefit levels: Gold *(80%),* Silver *(70%)* and Bronze *(60%)*
Cost	You will pay the full cost of the plan premium, plus an additional 2% admin fee	Monthly plan premiums may be subsidized by an ACA tax credit, depending on *household income*
Length of Coverage	Typically offered up to 18 months	Up to age 65, or upon the 25th month of SSDI

*Individual plans may only be purchased during the Open Enrollment Period (November 1 – December 15), or within 60-days of a qualifying event.

VOYAGE BENEFITS
MEDICARE & HEALTH PLAN SOLUTIONS

THANK YOU!

How to contact us for assistance:

- Phone: (616) 451-3300
- E-mail: ksyren@voyagebenefits.com
- Website: www.voyagebenefitsllc.com