THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

# CHOOSING HEALTHCARE AT RETIREMENT

THE BENEFITS PLAN OF THE
PRESBYTERIAN CHURCH (U.S.A.)

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Published by the Board of Pensions for the retiring/retired members of the Benefits Plan of the Presbyterian Church (U.S.A.), this booklet is intended to provide a general overview of Medicare and certain healthcare coverage options available during retirement. It may not provide all the information you need to make a decision about your healthcare coverage. The information provided in this booklet is subject to change.

For more information about healthcare coverage in retirement, contact your personal financial adviser. For more information about Medicare, visit Medicare's website, medicare.gov or call Medicare at 800-633-4227 (800-Medicare).

# 1. Introduction

*"Medicare Part A" … "Medigap" … "secondary coverage" … The healthcare system can be challenging enough to navigate without having to learn a special language, too. The Board of Pensions is here to help you understand your healthcare coverage options when you retire at age 65 or older. We are here to help you make the choices that are right for you and your circumstances now, and to help you understand that you may need to revisit these decisions in the years ahead.*

## What happens to my healthcare coverage when I retire?

Your healthcare coverage under the Active Medical Plan of the Presbyterian Church (U.S.A.) ends when you retire.

### If age 65 or older

You can enroll in Medicare, a federal health insurance program for people ages 65 and older, and for people younger than age 65 who have certain disabilities.

Medicare provides the foundation for your healthcare coverage in retirement. But it may not provide the full extent of coverage that you need. For that reason, a number of supplemental policies are available on a subscription basis, which means you pay the cost.

### If younger than age 65

You may be eligible for medical continuation coverage or other qualified healthcare coverage. You can find information about medical continuation coverage on **pensions.org**.

### Why should I read this? If the Board offers coverage, that's all I need to know …

The Board is providing this booklet because healthcare coverage is not one size fits all. Your personal circumstances should drive your decision, as some plans may be more appropriate for certain circumstances than others.

To ensure that you are appropriately covered at a cost you can afford, you need to understand Medicare — what it provides, what it doesn't, and how other coverage can complement it. Otherwise, you may pay more than is necessary for your needs or expose yourself to a risky gap in coverage.

This booklet offers a high-level look at what Medicare provides, where the gaps are, and the types of plans available to fill those gaps. The Board is pleased to offer this booklet and other helpful resources to assist you in preparing for retirement. But in the end, only you can decide which coverage is best for you.

## 2. Medicare in Brief

Making the transition from employer-based coverage to the federally funded Medicare program can be a challenge. That's because, in general, your coverage under the Medical Plan of the Presbyterian Church (U.S.A.) while you are working is more comprehensive than your coverage under Medicare during retirement. What's more, you are responsible for the cost of your healthcare coverage throughout your retirement.

You'll want to consider how you will cover the cost of any care you may need that exceeds the limits of your Medicare coverage. To do that, you need a good understanding of the Medicare program.

### What is Medicare?

Medicare is a federally funded system of health insurance established in 1965. It assists people in paying their medical costs at ages 65 and older, or before age 65 if they have certain disabilities.

There are two ways to get your Medicare coverage:

- through providers you choose (Original Medicare), or
- using a managed care plan (Medicare Advantage)

As a member of the Medical Plan of the Presbyterian Church (U.S.A.), you already are familiar with the first way, in which providers, such as doctors, hospitals, and labs, bill fees for the services they provide. Most plans, including your coverage under the Medical Plan while you are working, cap, or limit, the amounts paid to participating providers. That's also how Original Medicare works. Less familiar but no less effective is the second way, in which care is managed by a private insurer. Additional services typically are covered in exchange for certain restrictions on where you can go for care. That's how Medicare Advantage plans work.

You will need to choose which of the two ways works best for you.

## Choice 1: Original Medicare

Original Medicare is a fee-for-service type of coverage provided by the government for many healthcare services and supplies. It consists of two parts: Part A, hospital insurance, and Part B, medical insurance. With Original Medicare, you also can add Part D coverage, an outpatient prescription drug plan.

### Part A`

Part A helps pay:

- the costs of a stay in the hospital
- some follow-up costs after hospitalization
- skilled nursing facility, hospice, and home healthcare expenses

Most people ages 65 and older do not pay a premium for this coverage, as they and their employers paid Medicare taxes throughout their working years to fund this coverage. Most U.S. hospitals accept Medicare Part A coverage, so access to hospital care generally is not an issue.

### Part B

Part B pays:

- some of the cost of doctors' services and outpatient medical care
- some preventive care services

You pay a monthly premium for this optional coverage. Most physicians accept Medicare Part B coverage, so access to physician care generally is not an issue.

More information about Part A and Part B can be found in Chapter 3, Original Medicare.

**Premium** – a fixed amount you have to pay, usually monthly, to participate in a plan or program.

### Part D

Part D, added to Medicare in 2006, pays:

- some of the cost of outpatient prescription drugs

You pay a separate monthly premium for this optional coverage. Part D plans are managed by private health insurers, and not all cover the same drugs.

More information about Part D coverage can be found in Chapter 5, Prescription Drug Coverage.

## Choice 2: Medicare Advantage

Also known as **Part C** plans, Medicare Advantage plans offer an alternative to Original Medicare. They typically provide all-in-one coverage for hospitalization and physician services and are offered by private companies approved by Medicare.

A Medicare Advantage plan *must* provide:

- Part A benefits
- Part B benefits

It also may include:

- Part D coverage
- additional benefits, such as vision, hearing, dental, and/or health and wellness programs

When you choose to get your Medicare coverage through one of these plans, you typically pay two premiums for covered services: a monthly premium and a Part B premium.

Various Medicare Advantage plans provide your Medicare coverage by different means. Some are set up as HMOs, others as PPOs, and still others as private fee-for-service plans. This means they have different rules for how you get services (referral requirements differ, for example), and require you to use specific provider networks. They also can charge you different out-of-pocket amounts as well as different premiums. Generally, you must live in a Medicare Advantage plan's service area to join it. More information about Medicare Advantage plans can be found in Chapter 4, Medicare Advantage Plans.

**The Humana Group Medicare Advantage PPO plan**

The Board of Pensions offers medical coverage to eligible retired members through the Humana Group Medicare Advantage PPO plan with no monthly subscription rate to participate.

The plan is a Medicare Part C (Medicare Advantage) plan that is unique to retired members of the Benefits Plan. It offers all the benefits of Original Medicare (Parts A and B), prescription drug coverage, plus extras like dental, vision, and hearing aid benefits and a variety of wellness, clinical, and fitness programs.

Read more about the Humana plan in Chapter 7 of this booklet.

### Important terms

**HMOs** – health maintenance organizations; a type of managed care organization in which the affiliated doctors and hospitals have agreed to treat patients in accordance with the HMO's guidelines for a set reimbursement amount.

**PPOs** – combinations of hospitals and physicians that agree to render particular services to a group of people, typically under contract with a private insurer; also, healthcare delivery systems that contract with providers to provide services at discounted fees to members.

**Fee-for-service plans** – health insurance plans in which you are not limited to specific doctors and hospitals, and insurance pays according to a schedule for the services performed.

## Your Medicare Choices

First decide whether you want to get your Medicare the traditional way through Original Medicare, or from a private company through Medicare Advantage. In subsequent steps, you decide whether to supplement your basic Medicare benefits with additional "parts" of Medicare, as needed.

**This guide gives** you a good foundation for researching Medicare coverage, but it can't help you pick specific plans. You'll need to compare your healthcare and budget needs with what the individual plans have to offer.

<table>
<tr><th colspan="3">Step 1<br>Decide if you want Original Medicare or a Medicare Advantage plan</th></tr>
<tr><th>Original Medicare</th><th colspan="2">Medicare Advantage plan</th></tr>
<tr><td>Part A, hospital insurance<br>Part B, medical insurance</td><td colspan="2">Part C (includes Part A and Part B),<br>but like an HMO or PPO:<br>• may include prescription drug coverage, depending on plan<br>• may include supplemental benefits, depending on plan</td></tr>
<tr><th>Step 2<br>Decide if you want prescription drug coverage</th><th colspan="2">Step 2<br>Decide if you want prescription drug coverage</th></tr>
<tr><td>Part D, prescription drug coverage*</td><td colspan="2">(If choosing the Humana Group Medicare Advantage PPO plan skip to step 3)<br>Part D, prescription drug coverage<br>(if not included in your Part C plan)</td></tr>
<tr><th>Decide if you want Medicare supplement insurance such as a Medigap plan</th><th colspan="2">Step 3<br>Choose between</th></tr>
<tr><td></td><td>The Humana Group Medicare Advantage PPO plan</td><td>Different/other Medicare Advantage plan</td></tr>
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*If you don't join a Medicare prescription drug plan when you are first eligible, you'll pay a **late enrollment penalty** unless you have similar prescription drug coverage (called creditable coverage) from an employer or union. Because it is added to your premium for as long as you have Medicare drug coverage, a late enrollment penalty can be quite costly.

## How is Medicare financed?

In most cases, your healthcare coverage is funded largely by your church or other employer while you work. In retirement, your healthcare coverage is financed by the government (through Medicare) and you.

Medicare funding comes from three sources:

- payroll tax contributions (from current workers and employers)
- general revenues (drawn mostly from federal income taxes)
- the premiums you pay

Most of the funding comes from the first two. As a result, the expense of purchasing healthcare coverage in retirement may be more affordable than you think.

**Note:** Help is available for those who cannot afford the premiums for Part B and Part D coverage. If you have limited income and resources, you can get more information from Social Security or your state Medicaid office.

The following chapters provide an overview of each of the "parts" of Medicare, as well as the Humana Group Medicare Advantage PPO plan offered by the Board of Pensions.

# 3. Original Medicare

*Signed into law by President Lyndon B. Johnson in 1965, the Social Security Act — the original Medicare act — gave seniors access to basic health and hospital benefits, regardless of health status, financial means, or advanced age. It has provided millions of Americans with a source of healthcare coverage during their retirement years, and still does today.*

*This chapter looks at key factors to consider when deciding which Medicare coverage is right for you: eligibility, enrollment, cost, benefits, and claims payments.*

## Am I eligible?

### Part A

- Almost anyone age 65 or older is eligible for Part A benefits under Original Medicare.

### Part B

- If you are age 65 or older and have been a legal U.S. resident for at least five consecutive years, you are eligible to enroll in Medicare Part B medical insurance.

**Medicare coverage** begins at age 65 regardless of when you begin to receive Social Security benefits.

## How do I enroll?

### Part A

**If you will be getting benefits from Social Security**, you are automatically enrolled in Part A starting the first day of the month you turn 65. You will get your Medicare card in the mail three months before your 65th birthday.

*If your card does not arrive in the mail three months before your 65th birthday, immediately contact Social Security. This will allow them time to enroll you so that coverage will be in place when you turn 65.*

**If you will not be getting benefits from Social Security** (for instance, because you are still working), you still should enroll in Part A. Contact Social Security three months before your 65th birthday to sign up. This will allow them time to enroll you so that coverage will be in place when you turn 65.

### Part B

**If you will be getting benefits from Social Security**, in most cases you will also automatically be enrolled in Part B starting the first day of the month you turn 65. You will be responsible for paying a monthly premium for this coverage. If you don't want Part B coverage, you must let Social Security know before the effective date on the front of your Medicare card.

If you decide to keep Part B coverage, the monthly premium will automatically be deducted from your Social Security benefit payment. If you don't get a Social Security benefit payment, Medicare will bill you directly.

**The Centers for Medicare & Medicaid Services (CMS)** administers the Medicare program, but you apply for Medicare through the Social Security Administration.

**If you will not be getting benefits from Social Security** because you are still working, you'll likely want to contact Social Security to defer enrollment in Part B until you retire. You can do this without penalty if you have medical coverage through your employer.

### Proof of coverage

**Show your Medicare card** to your hospital or medical care provider whenever you seek services. Note that the effective dates of both your Part A coverage and your Part B coverage, if you enroll, are listed on the front of your card.

## What do I pay?

### Part A

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid **Medicare taxes while working**. If you aren't eligible for Part A without charge, you may be able to buy it.

When you receive a Part A service, you must pay an initial amount — a hospital insurance **deductible** — before Medicare will pay its portion. **Copayments** and **coinsurance** also may apply.

### Part B

You pay the **monthly premium**, which depends on your yearly income and when you sign up for Part B. The premium amounts usually change each year.

Deductibles, copayments, and coinsurance may apply for any Part B service.

*If you did not pay into Social Security during your years of employment and you do not qualify through your spouse, Medicare coverage is still available to you, but at a significantly higher rate. Contact Social Security for more information.*

## What's covered?

Medicare covers the following services, subject to a deductible, copayments, and coinsurance. Services must be medically necessary. Additional rules and limits may apply, depending on the type of service and facility. For details, refer to the "Medicare & You" handbook, which is provided annually to Medicare-eligible individuals, and is available at medicare.gov.

Here's a brief look at services that are generally covered by Medicare Part A and Part B.

| Part A covers: | Part B covers: |
|---|---|
| **hospital stays:** semi-private room, meals, general nursing, drugs, and other hospital services and supplies; includes care in inpatient rehabilitation facilities<br>**skilled nursing facility care:** semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies<br>**home healthcare services:** can include part-time or intermittent skilled nursing care, and physical therapy, speech-language pathology services, and occupational therapy<br>**hospice care:** includes drugs and medical and support services from a Medicare-approved hospice | **medical and other services:** doctors' services, outpatient medical and surgical services and supplies, diagnostic tests, durable medical equipment, and more<br>**laboratory services:** blood tests, urinalysis, and some screening tests<br>**home healthcare services:** can include part-time or intermittent skilled nursing care, and physical therapy, speech-language pathology services, and occupational therapy<br>**outpatient hospital services:** hospital services and supplies you get as an outpatient as part of a doctor's care<br>**many preventive care services:** includes annual well visits, mammograms, Pap tests, prostate cancer screenings, bone density tests, annual flu shots, and more |

## What's not covered?

Medicare pays only a portion of Part A and Part B services; it does not cover the services or items in the following chart. Additional rules and limits may apply, depending on the type of service and facility. For details, refer to the "Medicare & You" handbook at medicare.gov.

Here's a partial list of what's **not** covered. These are some of the key gaps for which you may want supplemental coverage; visit medicare.gov for more information.

| Part A does not cover: | Part B does not cover: |
|---|---|
| **During a hospital stay:**<br>• the deductible for days 1-60 of a hospital stay for each **benefit period** ($1,676 for 2025)<br>• the coinsurance amount for days 61-90 of a hospital stay ($419 per day for 2025)<br>• the coinsurance amount for days 91-150 of a hospital stay ($838 per day for 2025)<br>• any cost for each day beyond 150 of a hospital stay<br>• medical expenses incurred while traveling outside the United States<br>**During a stay in a skilled nursing facility:**<br>• the coinsurance amount for days 21-100 for each benefit period ($209.50 per day for 2025)<br>• any cost for each day beyond 100 in a benefit period<br>• custodial care<br>**For home healthcare:**<br>• 20% of the approved cost of durable medical equipment or approved non-skilled care<br>• any cost for nonmedical personal care services<br>**Other:**<br>• long-term nursing home care | **For doctors, clinics, laboratories, therapies, medical supplies, and equipment:**<br>• the annual deductible ($257 for 2025)<br>• 20% of the Medicare-approved amount for most doctor services<br>• 15% above the Medicare-approved amount if provider is not a Medicare participating provider (Note: You cannot be billed more than this.)<br>• 20% of the Medicare-approved amount for outpatient hospital services<br>• 35% of the Medicare-approved amount for most outpatient mental healthcare<br>• some routine examinations and testing (e.g., eye exams related to prescribing glasses, exams for fitting hearing aids)<br>• glasses, hearing aids, or dentures<br>• prescription drugs<br>• most dental care<br>• routine foot care (unless you have diabetes-related nerve damage and/or meet certain conditions)<br>• acupuncture<br>• most chiropractic services<br>• treatment that is not considered medically necessary<br>• concierge care |

**Important**! Unlike your coverage under the Medical Plan while you were actively working, Original Medicare does not cap your out-of-pocket costs. This means there is no limit to, or ceiling on, your costs in the event of catastrophic illness unless you are protected by supplemental health insurance.

## How are claims paid?

Although many do, not every physician or supplier of healthcare equipment agrees to Medicare's rates, which affects how claims are paid. Some always do, others sometimes do, and still others never do. Make sure you know whether your doctor or supplier is enrolled in the Medicare program and always accepts Medicare's reimbursement, called assignment, at Medicare-approved rates, plus any applicable deductible or coinsurance, as payment in full. If so, that doctor or supplier is a participating provider. You'll have the lowest out-of-pocket costs with a Medicare participating provider, and the doctor's office will bill Medicare directly.

Nonparticipating physicians may choose to accept assignment on a case-by-case basis. Regardless of whether your doctor accepts assignment in your case, the doctor's office still sends the claim to Medicare for you, and Medicare reimburses you for Medicare-approved charges. If your doctor does not accept assignment, you may have to pay an amount exceeding what Medicare allows for the service — up to 15% more.

**You can limit** your out-of-pocket costs by choosing providers or suppliers who accept Medicare assignment.

Some physicians don't participate in Medicare at all except to provide emergency care. These are called private contract doctors. Medicare will not pay the doctor, or you, for the services you receive, and there's no limit to the amount the doctor may charge.

Similarly, some healthcare equipment suppliers do not participate in the Medicare program. If you rent equipment from a supplier who is not enrolled, Medicare will not pay; you will be responsible for paying the entire bill for any equipment or supplies from this provider. If you have Original Medicare, be sure to ask your healthcare provider and/or supplier if they participate in the Medicare program.

### Keeping track of your claims

With Original Medicare, you'll receive a Medicare Summary Notice (MSN), similar to Highmark Blue Cross Blue Shield's Explanation of Benefits. The MSN is not a bill. It shows which services and supplies were billed to Medicare during the previous three months, what Medicare paid, and what you may owe the providers.

If you already know you are choosing Original Medicare for your Medicare coverage, skip to Chapter 5, Prescription Drug Coverage.

# 4. Medicare Advantage Plans

*Medicare Advantage plans were created to give you greater choice in your healthcare coverage at retirement. Offered by private companies approved by and under contract with Medicare, each must provide the same benefits as Original Medicare, but various plans can deliver those benefits by different means. Typically, Medicare Advantage plans also include additional coverage, such as prescription drug, vision, hearing, and even dental benefits.*

*If you choose one of these plans, the company offering the plan takes responsibility for managing all aspects of your healthcare, including claims and billing. This can mean a lot less paperwork for you. Keep in mind, though, that the quality and scope of these plans can vary widely. It's important to thoroughly research the plans available in your area so that you can choose the plan that meets your specific needs.*

**The Medicare Advantage plans** described on these pages *are different from* the **Humana Group Medicare Advantage PPO plan**, which is **a unique plan offered to eligible retired members of the Benefits Plan of the Presbyterian Church (U.S.A.)**. The Humana Group Medicare Advantage PPO plan is described later in this booklet.

## Am I eligible?

Medicare Advantage plans must follow rules set by Medicare:

- If you are eligible for Part A and Part B coverage, you are eligible for a Medicare Advantage plan.
- You must live in the service area of the plan you select, unless you are in an employer-sponsored plan.

## How do I enroll?

If you choose to join a Medicare Advantage plan, you enroll yourself any time during your initial eligibility for Medicare. This is the seven-month period that begins three months before you turn 65, includes the month of your birthday, and ends three months after you turn 65. Depending on the plan, you may be able to join by completing a paper application, calling the plan, or enrolling through the plan's website.

Generally, you must stay enrolled for the calendar year, with one exception: You can switch to a 5-Star Medicare Advantage Plan between December 8 and November 30 the following year. You can only use this 5-star special enrollment period once during this time frame. (A 5-Star Plan is one that Medicare has awarded with its highest rating.) For information, visit medicare.gov.

Your coverage renews automatically from year to year, provided you pay the premium and the plan is still available in your service area.

## What do I pay?

Every month, Medicare pays a fixed amount for your care to the company offering the Medicare Advantage plan you choose. In addition, you may pay a **monthly premium** for the plan and your **Part B premium**.

Costs for items and services vary by plan, although many Medicare Advantage plans cap your out-of-pocket costs.

## What's covered, and what's not?

Medicare Advantage plans cover all the services that Original Medicare covers, except hospice care. (Original Medicare covers hospice care even if you're in a Medicare Advantage plan.) See Chapter 3, Original Medicare, to review the basic benefits covered by and excluded from any Medicare Advantage plan.

Most Medicare Advantage plans offer some extra coverage, such as vision, hearing, or dental benefits, and many offer prescription drug coverage. If your plan does not offer prescription drug coverage, you can join a Part D plan to add such coverage.

**Note:** You don't need and can't use a Medigap policy with a Medicare Advantage plan. (See Chapter 6, Medigap Plans.)

## What types of plans are offered?

Different types of Medicare Advantage plans include:

- Health Maintenance Organization (HMO) plans
- Preferred Provider Organization (PPO) plans
- Private Fee-for-Service (PFFS) plans
- HMO Point of Service (HMOPOS) plans
- Medical Savings Account (MSA) plans
- Special Needs plans (SNP)

**Medicare Advantage plans** were previously known as Medicare + Choice plans. They're also sometimes referred to as Medicare Part C plans.

- Not every type of Medicare Advantage plan is available in all regions of the country. For more information, see the "Medicare & You" handbook, available on medicare.gov.

## How to find and compare plans

It's important to take the time to understand differences between individual plans. To find and compare Medicare Advantage plans in your area, go to medicare.gov and select **Health & Drug Plans**, then click **Find health & drug plans**. This tool will allow you to see how plans in your area compare to each other, so that you can gather preliminary information before contacting certain plans. It also provides phone numbers for each plan.

Call the companies offering the Medicare Advantage plans that provide the coverage you are seeking. They can give you the cost information you need to complete your comparisons.

It will be worth your while to make close comparisons. Making the right choice can save you significant dollars.

- **Even if you know you are choosing a Medicare Advantage plan that covers prescription drugs, read about prescription drug coverage in this booklet. Much of the information it contains applies to any Medicare Part D coverage, whether provided through a stand-alone plan or a Medicare Advantage plan.**

# 5. Prescription Drug Coverage

*Medicare prescription drug coverage — Medicare Part D — was introduced in 2006 to help seniors pay for prescription drugs taken at home. Offered by private insurers and partially subsidized by Medicare, Part D plans must provide at least a standard level of coverage established by Medicare. Beyond that, benefits vary by plan.*

*Part D coverage may be added to, or included with, your Medicare healthcare coverage. You pay a separate premium for any coverage that you "add." If you choose Original Medicare for your Medicare healthcare coverage, you can add a Part D plan. If instead you join a Medicare Advantage plan, it may already include Part D benefits. If it doesn't, you can add a Part D plan to your coverage. The Humana Group Medicare Advantage PPO plan offered to retired members includes Part D coverage.*

*With the high cost of prescription drugs today, having prescription drug coverage is more essential than ever, especially as you age. The Board of Pensions recommends that you have some form of prescription drug coverage during retirement.*

## Am I eligible?

To join a Medicare Advantage plan with prescription drug coverage, or a stand-alone Medicare prescription drug program (i.e., a Medicare Part D plan), you must be eligible for both Medicare Part A and Medicare Part B. You also must live in the service area the plan serves.

## How do I enroll?

You have choices. You can enroll for coverage with a stand-alone Medicare Part D plan offered by an insurance carrier, or, if eligible, you can enroll in the Humana Group Medicare Advantage PPO plan offered by the Board of Pensions, which includes Part D coverage.

If you choose a stand-alone plan, contact the company offering it for enrollment information. Depending on the company, you may be able to join by calling the plan, mailing or faxing a completed enrollment form, or enrolling online.

When you first become eligible for Medicare, you can join a stand-alone Part D plan three months before the month you turn 65 to three months after the month you turn 65.

**Note**: If you don't join a Medicare prescription drug plan when you are first eligible, you'll pay a **late enrollment penalty** unless you have similar prescription drug coverage (called creditable coverage) from an employer or union. Because it is added to your premium for as long as you have Medicare drug coverage, a late enrollment penalty can be quite costly.

There is an exception to this enrollment window if you are eligible for and wish to enroll in the Humana Group Medicare Advantage PPO plan, which includes Part D coverage. As long as you are actively working with medical coverage through the Board of Pensions, regardless of your age, you have creditable prescription drug coverage. When you retire, if you are eligible, you may enroll — or waive immediate enrollment — in the Humana Group Medicare Advantage PPO plan as soon as possible, but no later than 60 days after your last day of coverage as an active member of the Medical Plan. (To review the eligibility rules, see Chapter 7, Humana Group Medicare Advantage PPO plan.)

## What do I pay?

Medicare Part D coverage costs vary, depending on your choice of plan.

Remember, it's important to take the time to understand and compare Medicare prescription drug plans so that you can find the most appropriate coverage for the most reasonable cost.

### The Humana Group Medicare Advantage PPO plan

Under the Part D coverage offered through the Humana Group Medicare Advantage PPO plan, your copayment for each prescription will vary depending on which of four tiers (categories) your medication is in. For example, you pay just a $5 copayment for Tier 1 (generic or preferred generic) prescriptions. The plan caps your out-of-pocket costs at $2,000 annually. Even if you fill only a few prescriptions a year, you can limit your costs. The plan is easy to use because there are no deductibles or claim forms. The following explanation applies to Medicare Part D stand-alone plans, not Part D coverage offered through the Humana Group Medicare Advantage PPO plan for eligible retired Benefits Plan members.

**The Board of Pensions** offers a qualified Medicare Part D plan as part of retiree medical coverage through the Humana Group Medicare Advantage PPO plan.

### Medicare Part D Stand-Alone Plans

**Premium and deductible** *In general*, if you enroll in a stand-alone Part D plan at your earliest opportunity, you will pay a **monthly premium**, which varies by plan. In 2025, you may also pay a $590 **annual deductible**.

**Coinsurance** In addition, in most stand-alone plans, you pay a percentage of the retail cost of your prescriptions — called coinsurance. In general, you usually pay **25%** of your annual drug costs, and your plan pays 75%.

Starting in 2025, all Medicare Part D plans will include a $2,000 annual cap on what you pay out-of-pocket for prescription drugs covered by your plan. If your out-of-pocket spending on covered drugs reaches $2,000, you'll automatically get "catastrophic coverage," which

means you won't have to pay out-of-pocket for covered Part D drugs for the rest of the calendar year.

If you pay coinsurance, these amounts may vary because drug plans and manufacturers can change what they charge at any time throughout the year.

**Copayment** On top of your coinsurance, you may be responsible for a flat fee amount, or copayment. The copayment varies based on the tier of drugs, and whether it is a brand-name or generic drug.

**Note**: Extra help for paying your Medicare prescription drug plan costs is available, based on financial need. Contact Social Security for information.

## What's covered, and what's not?

This is one of the most important questions you can ask about a Medicare prescription drug plan, and the answer varies from plan to plan.

In general, Medicare prescription drug plans cover generic and brand-name drugs that you take while not confined to a hospital or other inpatient facility. All plans must cover the same categories (or classes) of drugs, but individual plans can choose which specific drugs they will cover for each category. Before you join a plan, you'll want to confirm that all your prescription drugs are covered by your chosen plan and check to see how much you will pay for them. For drugs that are not covered under your plan, you pay 100% of the cost.

Be aware that Medicare prescription drug plans routinely add and subtract drugs from their list of covered drugs, or formulary. **Each fall, when plans announce their new formularies for the following year, it's important to review your plan's list to make sure your prescriptions continue to be covered.** If they are not, you may want to consider changing plans.

If you have a Medicare Advantage plan with prescription drug coverage, you must go to a pharmacy that participates in that particular plan or else your plan may not pay.

**If you have Original Medicare** and enroll in a Part D plan, ask your pharmacy if it participates in the Medicare program. If you go to a pharmacy that does not participate, Medicare will not pay. You will be responsible for paying the entire bill for any prescription filled at this pharmacy.

## How to find and compare plans

To find and compare stand-alone Part D plans in your area, go to medicare.gov. and select **Health & Drug Plans**, then click **Find health & drug plans**. This tool can help you find which plans in your area cover your prescriptions and which pharmacies you can use to fill them.

Once you've identified possible plans based on coverage, contact the plans for particulars. The difference between deductibles, coinsurance, and copayments should play a significant role in plan selection. In addition, some plans have coverage rules, like prior authorization and step therapy, or discount mail-order programs for maintenance drugs. These may be familiar to you, as your coverage under the active Medical Plan has/had them. The presence or absence of these rules and programs also may influence your choice.

- **To learn more about the Humana Group Medicare Advantage PPO plan, including its Part D coverage, see Chapter 7, the Humana Group Medicare Advantage PPO plan.**

**Prior authorization** – a formal process for obtaining approval from a service provider or health insurer before a certain prescription can be filled.

**Step therapy** – a formal process that requires certain therapies or medications be tried before more complex, expensive therapies are covered as eligible expenses.

# 6. Medigap Plans

As should be clear from the preceding pages, Medicare does not cover all your healthcare costs in retirement — and in some instances, not even half of the costs. Moreover, with Original Medicare you have unlimited out-of-pocket costs. For this reason, many private insurers offer Medicare supplement insurance policies — Medigap, for short — to help pay some of the costs Original Medicare doesn't cover.

These policies must follow federal and state laws designed to protect you, and they must be clearly identified as Medicare supplement insurance. In most states, Medigap policies are standardized and named by letters: A-D, F, G, and K-N. (These letters have no relationship to the Medicare Part A, B, C, and D designations.) Each standardized Medigap policy must offer the same basic benefits, no matter which company sells it. Cost is usually the only difference between policies that share the same letter designation but are sold by different companies.

## Am I eligible?

If you have Original Medicare (Part A and Part B), you are eligible to buy a Medigap policy.

**Note:** If you have Medicare Advantage, you are not eligible, as Medicare Advantage plans already include supplemental coverage.

Once you are covered, the insurance company can't cancel your policy as long as you pay the premium.

## How do I enroll?

Contact the company offering the plan for this information. Depending on the company, you may be able to join by calling the plan, mailing or faxing a completed enrollment form, or enrolling online.

You have a **six-month open enrollment period** to buy your Medigap policy. It begins the first month that you are age 65 or older and enrolled in Medicare Part B. During this period, you can buy any Medigap policy sold in your state; you cannot be denied coverage or charged a higher premium for your Medigap policy because of health problems.

After this period, you may not be able to get a Medigap policy at a later date, or you may be charged a higher premium.

## What do I pay?

Medicare doesn't pay any of the costs for you to get a Medigap policy. You'll pay a **monthly premium** directly to the private insurance company you buy the policy from, in addition to your **Part B premium**.

The premiums charged for a particular level of benefits vary by company and by state.

## What's covered?

All standardized Medigap policies offer the same basic benefits, but some offer additional benefits so you can choose which one meets your needs. The alphabet letter designations allow you to compare policies that provide the same benefits but are offered by different companies. By comparing a G plan to another G plan, for example, you know you are comparing apples to apples.

All Medigap plans fully cover these **basic benefits**:

- Part A coinsurance costs for up to an additional 365 days of hospital care after Medicare benefits are used up

All Medigap policies also cover, either fully or in part:

- Part B coinsurance or copayment
- first three pints of blood
- Part A hospice care coinsurance or copayment

Some policies fully or partially cover Part A deductibles and may also cover skilled nursing facility care coinsurance and emergencies when traveling outside the United States, either fully or in part.

The specific benefits provided by **Medigap Plans** are listed in Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, at medicare.gov.

**Note:** Plans E, H, I, and J are no longer sold.

## What's not covered?

Medigap policies don't cover long-term care (like care in a nursing home), vision or dental care, hearing aids, eyeglasses, and private-duty nursing.

New Medigap plans no longer cover **prescription drugs** or **Part B deductibles**, although people already enrolled in such coverage through an older Medigap policy are allowed to continue it. If you choose a Medigap plan, you can enroll in a Part D plan separately (see Chapter 5, Prescription Drug Coverage).

## How to find and compare plans

First you need to determine which benefits you need, then decide which of the Medigap plans, indicated by plan letter, best meets your needs.

Next, visit medicare.gov. Click **Health & Drug Plans**, then select **Find a Medicare Supplement Insurance (Medigap) policy** under **Find and Compare**.

Medicare recommends that you also contact your state insurance department for information you'll need to evaluate the insurance companies selling the policies.

In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized differently. If you live in one of these states, see "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," at medicare.gov, or contact your state insurance department for information.

# 7. The Humana Group Medicare Advantage PPO plan

*For many retiring members of the Benefits Plan of the Presbyterian Church (U.S.A.), healthcare coverage choices extend beyond Medicare's official programs. If you meet the eligibility requirements, you may choose to enroll in the Humana Group Medicare Advantage PPO plan. Regardless, Medicare provides your primary healthcare coverage in retirement.*

*Just as Medicare has evolved, incorporating private plans into its delivery system, so too have the healthcare coverage choices available to seniors. The quality and cost of some of these coverage opportunities make them worth your consideration. The Humana Group Medicare Advantage PPO plan may or may not be your best option for supplemental coverage. Evaluate which option will best meet your needs by assessing your coverage requirements and examining the full range of options available to you, as well as the associated costs.*

## Am I eligible?

The Humana Group Medicare Advantage PPO plan is available to qualifying members of the Benefits Plan when they retire. Certain family members also may enroll.

This section summarizes the eligibility requirements for the Humana Group Medicare Advantage PPO plan. For further details, visit pensions.org/humana.

### If you are working and preparing to retire

If you are working and are enrolled for coverage under either the Medical Plan or medical continuation, you may qualify for the Humana Group Medicare Advantage PPO plan at the time you retire if you are enrolled in Medicare Parts A and B.

If you are not participating in the Medical Plan at the time you retire, you still may be eligible for the Humana Group Medicare Advantage PPO plan. Contact the Board at 800-PRESPLAN (800-773-7752) (TTY: 711) for more information.

## How do I enroll?

If you are eligible for the Humana Group Medicare Advantage PPO plan, complete the Humana Group Medicare Advantage PPO plan enrollment form (included in the personalized retirement packet you receive after you notify the Board of Pensions of your retirement date) and return it, together with a copy of your Medicare ID card, to the Board of Pensions as soon as possible, but no later than 60 days after your last day of coverage as an active member of the Medical Plan.

## What do I pay?

### Premium

Retired members pay no monthly subscription rate to participate in the Humana Group Medicare Advantage PPO plan.

### Out-of-pocket costs

Because the plan is a Medicare Advantage plan, you must continue to pay your Medicare Part B premium.

You pay $0 for many types of healthcare services and supplies, including preventive care; in-person and virtual visits with a primary care physician; lab services, when performed in a primary care physician's (PCP's) office or in a free-standing laboratory; and home healthcare.

The annual deductible is $0 so you pay nothing before the plan begins to pay benefits for services.

For inpatient hospital care, the plan pays 100% after you pay a $320 copayment per admission.

For other types of services, the plan pays 96% of the cost, and you pay 4%; your share is called coinsurance. Examples of services that require you to pay coinsurance include:

- specialist care
- outpatient hospital services
- urgent care
- occupational, physical, and speech therapy
- durable medical equipment

For Tier 1 generic prescription drugs, you pay a $5 copay.

Out-of-pocket costs for all medical expenses are capped at $2,590 per year; prescription drugs have a separate out-of-pocket maximum of $2,000 per year.

For more details, visit pensions.org/humana or call Humana Customer Care at 855-273-0021 (TTY: 711).

## What's covered?

The Humana Group Medicare Advantage PPO plan provides all the benefits of Original Medicare (Parts A and B). The plan covers medically necessary items and services from a large national network of hospitals and physicians, as well as any doctor, specialist, or hospital that accepts Medicare and agrees to bill Humana.

### Prescription drug coverage

The Humana Group Medicare Advantage PPO plan provides prescription drug coverage — Medicare Part D — that is included in some, but not all, Medicare Advantage plans. In this plan, there are significantly more prescription drug options than the standard individual formulary.

Your prescription drug coverage under the Humana Group Medicare Advantage PPO plan covers medications in four tiers: Tier 1: Generic or Preferred Generic; Tier 2: Preferred Brand; Tier 3: Non-Preferred Drug; and Tier 4: Specialty tier. Specialty medications typically are used to treat complex conditions, such as cancer, hepatitis, and multiple sclerosis. They include high-cost injectable and oral medications and often have special product handling and distribution requirements.

You pay just a $5 copayment for Tier 1 Generic or Preferred Generic prescription drugs. Your cost for medication in each of the other tiers varies depending on the prescription and may be found in the Humana Group Medicare Advantage PPO Plan — Pharmacy Summary of Benefits posted at pensions.org/humana.

Out-of-pocket prescription expenses are capped at $2,000 annually. After you reach this maximum each year, the plan pays 100% of your total drug costs for the remainder of the year.

Be sure to review the Humana Group Medicare Advantage PPO Plan — Pharmacy Summary of Benefits available at pensions.org/humana when making decisions about your medical coverage. If you have a question about whether a particular drug is covered and what tier it is in, call Humana Customer Care at 855-273-0021 (TTY: 711).

### Added value for retirees

In addition to Part D prescription drug coverage, the plan also provides extras like dental, vision, and hearing aid benefits and a variety of wellness, clinical, and fitness programs. Following are some of the benefits offered:

- dental coverage for exams, teeth cleanings, X-rays, fillings, anesthesia, dentures, and crowns
- annual routine eye exams, eyeglasses (lenses and frames), and contacts
- part of your cost for hearing aids prescribed by an audiologist and annual routine hearing exam
- SilverSneakers health and fitness program
- Go365 wellness program by Humana
- Humana Care Management
- Humana Well Dine meal program
- smoking cessation
- advance care planning with MyDirectives
- health coaching
- Humana Neighborhood Center

## International travel

The Humana Group Medicare Advantage PPO plan includes worldwide benefits for emergencies, and, for 2025, retired members will have access to International SOS services when traveling abroad. Although the plan covers you if you need medical care while traveling abroad, it does not cover you for services if you reside outside the United States.

For coverage details, visit pensions.org/humana or call Humana Customer Care at 855-273-0021 (TTY: 711).

## Comparing available coverage

If you've decided to get your Medicare coverage through Original Medicare and plan to add supplemental coverage, you may want to compare the Humana Group Medicare Advantage PPO plan offered through the Board to several prospective Medigap plans in combination with Part D plans.

### Medigap

Because the Humana Group Medicare Advantage PPO plan is not a Medigap plan, an exact comparison cannot be made between the Humana plan and Medigap plans. Remember that, unlike some Medigap plans, the Humana Group Medicare Advantage PPO plan comes with **Part D prescription drug coverage**. It uses a drug list, or formulary, similar to the one the Medical Plan provides for active members.

### Part D

Next, compare the prescription drug coverage available through the Humana Group Medicare Advantage PPO plan to any Part D plans you're considering. Note the differences in coinsurance and copayment requirements among the plans. Be sure to compare the out-of-pocket costs for prescription drug coverage between all the plans you are considering.

Also, if you regularly take an expensive drug, find out if it is covered, and if so, what your out-of-pocket costs will be.

Read the next chapter, Deciding on Your Retirement Coverage, for help in deciding priorities and finally choosing your retirement healthcare coverage.

# 8. Deciding on Your Retirement Coverage

*Although you'll want to consider several factors, only a few are central to making the best healthcare coverage decision for yourself. The key drivers will be your personal circumstances — the state of your health, your financial resources, where you will live in retirement, and your tolerance for change.*

*If you are being treated by a specialist for rheumatoid arthritis, for example, one of the most important considerations for you may be whether you'll have access to that doctor in your new provider network when you retire. Or if you or a family member is willing to do the research, you may want to change plans, especially prescription drug plans, should coverage terms become less favorable. And if you choose to live outside of the United States, you will not be covered by Medicare, nor will you be able to use any gap or supplemental coverage, as these plans build on Medicare. But if your resources are limited, cost may be the most important consideration in choosing your healthcare coverage in retirement.*

## Key considerations

The prospect of choosing healthcare coverage at retirement can seem like a daunting task, especially at a time in your life that may involve other changes, such as moving or taking care of an elderly parent. But it will be well worth the investment of time to identify your healthcare coverage needs and options, and then to make a well-considered choice.

The easiest way to approach the task is to make a list of your key considerations. To determine these, do the following:

1. **List your specific health issues.** Are you diabetic? Does your bone density increase the likelihood of a hip injury? Does cancer run in your family? No one can be sure of what the future holds, but the answers to these and similar questions can help you assess your coverage needs.
2. **Decide whether a particular specialist has a certain expertise or experience with you that's critical to your continued care**. If so, having access to that doctor may be a non-negotiable consideration.
3. **List all the prescriptions you take and their retail cost.** Be sure all your prescriptions will be covered and what your out-of-pocket costs may be.
4. **Note where you plan to live in retirement.** Will you reside outside of the United States? If in the United States, will you live in one location in the summer and another in the winter? Are you moving to a region with a well-regarded HMO system? Your answer should influence whether you consider a Medicare Advantage plan or need to supplement your Medicare benefits in any way.

5. **Compare plan rules, especially those relating to enrolling in and leaving the plan**. Some plans are more limiting than others and may not work for your situation.

6. **For each plan, write down the total premiums, deductibles, coinsurance, copayments, and out-of-pocket expenses you are likely to incur in a year**. Compare them under a good case scenario (your best expected health) and a bad case scenario (serious, prolonged illness). Consider what benefits you will receive, if any, under the good case scenario. Then assess your ability to handle the cost of the bad case scenario for each plan.

7. **Consider availability within the plan of other coverage you may need, such as dental, vision, or hearing care**. When you add in these benefits, how do the plans compare? If you are in good health otherwise, plans with these features may be more attractive — you know you will get a tangible return for your money.

8. **Decide whether you or a family member has the skills to handle the paperwork for Original Medicare**. (Mainly, you will need to monitor notices or statements of claims paid to make sure that you are getting the full benefit to which you are entitled.) A Medicare Advantage plan handles the paperwork for you. You will need to have access to one, of course, and this option may not work if you live in different parts of the United States in summer and winter.

9. **Consider whether having a single source of healthcare plan information, billing, and support matters to you.** If you have a spouse and child on medical continuation through the Benefits Plan, and you qualify for coverage under the Humana Group Medicare Advantage PPO plan offered to retired members, it may be a better cost value and more convenient to enroll in the Humana plan, at least initially.

10. **Take into account your tolerance for change.** If you will be stressed and upset, rather than merely inconvenienced, by the termination of a plan and the need to find another, consider selecting a plan offered by a prominent, national insurer rather than a regional one. Regional plans are more likely to close (or significantly change) than national ones.

## Refining your list

After weighing all these factors, one or two will stand out as prime considerations for your circumstances. Whether it is physician access, geography, cost, plan stability, or some combination of these that matters to you most, identifying your key considerations should allow you to narrow your options to a few plans in a specific category.

Consider the number of stars Medicare has awarded the plan — the more, the better. Once you have done that, contact your state insurance department to see if any of the companies offering the plans have complaints lodged against them. Depending on the answer, you may wish to further edit your list.

## Making your choice

Finally, weigh the remaining plans against your secondary considerations. One or two plans (or combination of plans) should stand out. After checking your calculations one last time, you are ready to make your choice. Remember to enroll in your chosen plan(s) within the stated time frame and keep copies of your enrollment application(s) and related materials.

And regardless of which plan(s) you choose, be sure to periodically review your coverage, as needs and available coverage change.

Whatever your decision, the Board wishes you a happy and healthy retirement!

## Key Resources

Numerous resources are available to support your efforts to understand Medicare, research your options, and decide your retirement healthcare coverage. In fact, the amount of information can be overwhelming, and not all of it is accurate and objective. For that reason, the Board suggests that you turn to the key resources listed below when you are seeking answers to your Medicare coverage-related questions.

| Resource | For Information About | Phone Number | Website |
|---|---|---|---|
| Social Security | Enrolling in Medicare or replacing a lost Medicare card; help paying for Medicare prescription drug coverage; general questions about Social Security and Medicare | 800-772-1213<br>TTY: 800-325-0778 | socialsecurity.gov |
| Medicare | Medicare coverage details; Medicare health and prescription drug plan choices in your area | 800-633-4227<br>(800-Medicare)<br>TTY: 877-486-2048 | medicare.gov |
| State Insurance Department | Medicare Advantage and Medigap plans in your region; consumer complaints filed against private insurers | Varies by state[1] | Varies by state[1] |
| National Council on Aging | Advocacy for seniors and caregivers; referrals for services | Contact by email through website at https://www.ncoa.org/page/contact-us | ncoa.org |
| State or County Office on Aging | Advocacy for seniors and caregivers; referrals for services | Varies by state and county[2] | Varies by state and county[2] |
| Humana | The Humana Group Medicare Advantage PPO plan; basic Medicare questions | Humana Customer Care at 855-273-0021 (TTY: 711) | your.humana.com/boardofpensions |
| The Board of Pensions | Eligibility and how to enroll in the Humana Group Medicare Advantage PPO plan | 800-PRESPLAN<br>(800-773-7752)<br>(TTY: 711) | pensions.org/humana |

[1] To locate this information, enter the name of your state followed by *insurance department* in an internet search engine, or contact Medicare to get the telephone number for your local state insurance department.

[2] To find this information, enter the name of your state or county followed by *Office on Aging* in an internet search engine. For example, if you live in Pennsylvania, enter *PA Office on Aging*.

THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

2000 Market Street
Philadelphia, PA 19103-3298
800-PRESPLAN (800-773-7752) (TTY: 711)

pensions.org