MEDICARE SIMPLIFIED.

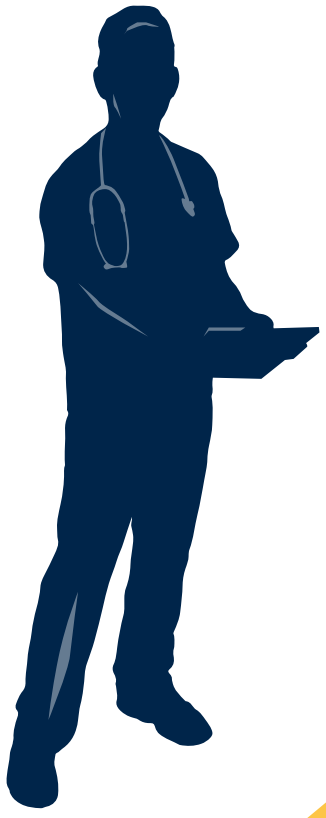
KNOW YOUR OPTIONS. KNOW THE COSTS.

Retirement. It often evokes pleasant thoughts of future travel, golfing, spending time with the grandchildren. But it also can bring up stress and concern. Do I have enough money? What if my health declines? How much money will I need for health care costs in retirement?

When planning for health care expenses in retirement, most Americans are aware that they will be eligible for Medicare at age 65. But what does this really mean? Does Medicare pay for all health care expenses in retirement? What's covered? What's not? As you prepare for retirement, sufficient attention must be paid to health care costs—even when you're on Medicare.

Medicare is a deductible and copay system that provides health care coverage. But, even after you become eligible for Medicare, you will still have health care expenses that you'll need to pay for. In fact, a recent study by the Employee Benefit Research Institute (EBRI) revealed that Medicare actually covers only about 60 percent of health care costs in retirement.[1] Fortunately, a little bit of knowledge and careful planning regarding health care expenses can make a big difference and can help safeguard your financial health in retirement.

Medicare covers only about 60 percent of health care costs in retirement.[1]



USE THIS GUIDE TO HELP YOU:

- Understand the types of health care costs most people encounter in retirement so that you can budget appropriately.
- Understand the different parts of Medicare.
- Identify what is and is not covered under Medicare.
- Avoid common pitfalls associated with enrolling for Medicare.

[1] Employee Benefit Research Institute, Savings Needed for Health Expenses for People Eligible for Medicare: Some Rare Good News pg 1, 2012

Northwestern Mutual®

THE COST OF HEALTH CARE IN RETIREMENT

If you are receiving health care through your employer today, you may be thinking that your costs in retirement will be the same or even lower once you sign up for Medicare. Unfortunately for most Americans, that's not the case; Medicare covers only a portion of your health care expenses. The additional costs are often attributed to the following:

- Dental, vision, hearing aids and other common health care expenses are not covered under Medicare.
- Additional costs for supplemental insurance, deductibles and copays may be more than what you are currently paying under employer-sponsored health care plans.

So what does all of this mean? It means that you have to be strategic about how you plan for health care costs and that your retirement budget reflects these anticipated expenses. According to the Employee Benefit Retirement Institute, if a couple aged 65 wanted to ensure a 90 percent chance of having enough savings for health care for their lifetime, a male would require $122,000 in savings and a female $139,000.[1] That number can seem overwhelming to many of us. Instead of trying to earmark a large sum of money for health care costs, consider using the chart to the right that shows the average annual costs that people approaching retirement should include in their budget. For example, if you are a person in good health, you would want to include approximately $5,000–$7,000 per year to cover out-of-pocket costs not covered by Medicare. This guide will help you understand your potential out-of-pocket costs to enable you to make informed decisions in selecting your Medicare plan as well as in creating your personal retirement plan.

ESTIMATED ANNUAL OUT-OF-POCKET HEALTH CARE EXPENSES IN RETIREMENT

65-year-old individuals on a per individual/per year basis

HEALTH	LOW	HIGH
Very Good—Excellent	$3,000	$5,000
Fair—Good	$5,000	$7,000
Poor	$7,000	$10,000

Estimates include the costs of premium, deductibles and copays. They do not include long-term care costs. Based on data from the Centers for Medicare and Medicaid Services, assume an annual inflation rate of 6 percent for health care expenses.

Source: www.medicare.gov

Get a better idea of your retirement expenses by using our Retirement Budget worksheets. ▶

WHAT IS MEDICARE?

Medicare is a federally administered social insurance program that guarantees access to health insurance for most Americans aged 65 and older. It also is available to certain individuals younger than age 65, including younger disabled workers and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD) and ALS (Lou Gehrig's disease).

[1] EBRI's 2013 Retirement Confidence Survey

THE FOUR PARTS OF MEDICARE

There are four parts to Medicare, each with its own coverage, costs and restrictions. The following are descriptions of each part and its associated costs. For reference purposes: Parts A and B described below are occasionally referred to as "Original Medicare" or "Traditional Medicare" on the Medicare.gov website.

MEDICARE PART A (HOSPITAL INSURANCE)

Medicare Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. To be eligible for Medicare Part A without additional cost, you or your spouse had to have had Medicare tax withheld from your paychecks for at least 10 years (or 40 quarters)[1] while you were working.

However, if you or your spouse didn't pay into the Medicare system for the required 10 years (40 quarters), you still have the ability to purchase Part A coverage. If you or your spouse worked between 30 and 39 quarters, the premium is $234/month per person in 2014. If you or your spouse worked less than 30 quarters, the premium is $426/month per person in 2014.

Unless you have other insurance coverage (for example, qualifying employer coverage), you are required to enroll in Medicare Part A at age 65.

PART A: DEDUCTIBLES AND COPAYS

For all covered individuals, there are additional deductible and coinsurance costs based on the type of care you may require. If you are hospitalized you are initially responsible for a $1,216 deductible for each "benefit period." Medicare defines a benefit period as the period beginning on the day you are admitted as an inpatient in a hospital or skilled nursing facility (SNF). It ends when you leave the hospital and do not receive additional care for 60 consecutive days. If you go back into a hospital after one period has ended, a new benefit period will begin with a new $1,216 deductible.

If your hospital stay exceeds 60 days, there is also a per-day coinsurance charge. The cost is based on how many days beyond 60 that you require care. The associated costs are:

- Days 61-90: $304 coinsurance per day.
- Days 91 and beyond: Individually pay or you can use your pool of Medicare "lifetime reserve days" at $608 coinsurance per day.
- Beyond lifetime reserve days: Individual is responsible for all costs.

WHAT ARE MEDICARE LIFETIME RESERVE DAYS?

When you enroll in Medicare Part A, you are given a pool of 60 days to help cover inpatient costs when care extends beyond 90 days per incident. These reserve days can be used only once during your lifetime but do not have to be applied toward the same hospital stay. You can either elect to use a lifetime reserve day or personally pay for the medical expenses through the hospital.

After the days are used, you are fully responsible for all inpatient costs beyond 90 days. It is your discretion on when you use them.

You may be wondering, when should I personally pay for out-of-pocket hospital expenses (beyond the Medicare-covered 90 days) versus using a lifetime reserve day? Typically, if the hospital costs are less expensive, for example maybe only one day of coinsurance, you may want to pay the costs yourself and reserve your lifetime days. If the costs are significant, you may want to use your reserve days. Another factor that could impact your decision is whether or not you purchased supplemental insurance; in most cases, supplemental insurance provides additional lifetime reserve days.

[1] In 2014, a "quarter" equals at least $1,200. You earn up to 4 quarters in any calendar year. Find more about "quarters" at http://www.socialsecurity.gov/retire2/credits1.htm

MEDICARE PART B (MEDICAL INSURANCE)

Medicare Part B covers two types of services—medically necessary services, which typically include doctors' visits and services, outpatient care, medical supplies, lab work, and x-rays; and preventive services. Unless you have other qualifying insurance, you are required to enroll for Part B.

PART B: PREMIUMS, DEDUCTIBLES AND COPAYS

There is a standard monthly premium of $104.90 per person for Medicare Part B in 2014. However, if your modified adjusted gross income is above a certain threshold amount, you will pay a higher monthly premium, known as the Income-Related Monthly Adjustment Amount (IRMAA). IRMAA would then be added to your standard monthly premium (high income is considered above $85,000 for an individual and $170,000 for a married couple in 2014).[1] This is covered in further detail in the Additional Costs section of this paper.

In addition to the monthly premium, there is an annual deductible of $147/year and a 20 percent copay for most doctor services, outpatient therapy, and durable medical equipment. There is no out-of-pocket maximum for Part B.

REQUIRED PLANS

You are required to enroll in Parts A, B, and D.

OPTIONAL PLANS

Part C, the Medicare Advantage plan, is an optional program run by private companies that administer Parts A and B versus Medicare.

Learn more about the costs of Medicare at Medicare.gov ▸

PART C (MEDICARE ADVANTAGE PLANS)

Medicare Part C is also known as a Medicare Advantage plan or MA plan. It's a type of Medicare health plan offered by private companies that contract with Medicare to provide you with all of your Part A and Part B benefits. These companies have agreed to provide coverage under rules established by Medicare. Medicare pays a fixed amount for your care each month to these Medicare Advantage companies. If you choose to join a Medicare Advantage plan, you still have Medicare. You have simply chosen to get your Medicare Part A and Medicare Part B coverage from the Medicare Advantage plan and not from Original Medicare. Medicare Advantage plans often operate as Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), which require you to utilize doctors within their predefined networks.

Medicare Advantage plans cover all Medicare services. Additionally, these plans will often offer extra coverage. For example, some Part C plans offer prescription drug coverage, as well as coverage for expenses not covered through Medicare Parts A and B, such as dental and vision.

PART C: PREMIUMS, DEDUCTIBLES AND COPAYS

All Medicare Part C Advantage plans include a monthly premium and copay similar to Original Medicare, but they can charge different out-of-pocket costs and have different rules for how to obtain services. For example, Medicare Advantage may require you to get a referral to see a specialist or may require you to use regional providers within their network. These rules can also change each year. So, while using a Medicare Advantage plan will cover more services, it might not be a wise option for people who want to use certain doctors or hospital systems or for those who travel extensively.

[1] U.S. Social Security Administration https://secure.ssa.gov/poms.nsf/lnx/0601101020

MEDICARE PART D (PRESCRIPTION DRUG COVERAGE)

Medicare Part D is the part of Medicare that provides outpatient prescription drug coverage. These are drug plans offered by private insurance companies that contract with Original Medicare. It's important to note that Medicare Part C plans, as discussed above, may also offer for no additional charge prescription drug coverage that follows the same rules as Medicare prescription drug plans.

PART D: PREMIUMS, DEDUCTIBLES AND COPAYS—AND THE DREADED "DONUT HOLE"

There is a monthly premium for Medicare Part D plans, and the monthly premium varies based on the plan you select. Since different plans cover different drugs, it is essential that you compare and decide which plan gives you the best coverage for the medications you're on. Similar to Parts A and B, you are required to enroll for coverage. And like Medicare Part B, if your modified adjusted gross income is above a certain threshold amount, you will pay an IRMAA.[1] (See the Additional Costs section of this paper for more information.)

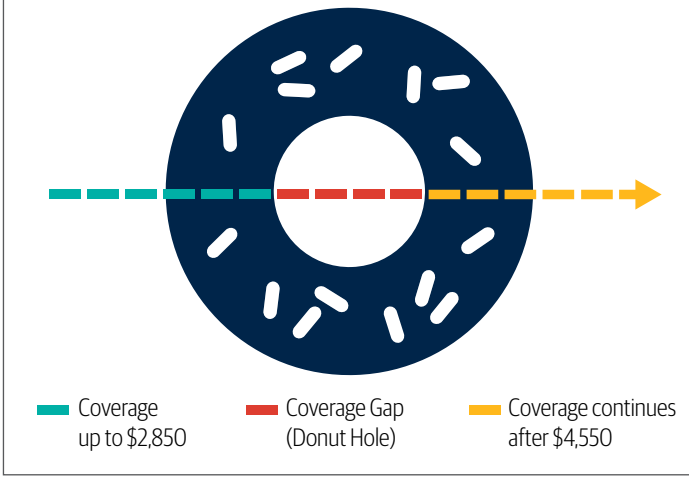
Perhaps the most confusing aspect of Part D coverage involves the deductibles, copays and the coverage gap commonly referred to as the "donut hole."

Medicare Part D has an initial deductible of $310 (2014 figure). After the deductible, there is a 25 percent copayment on prescription drugs until the total retail costs equal $2,850 (2014 figure). This is where the coverage gap—or donut hole—begins.

Once you're in the coverage gap, you are responsible for your prescription costs until the retail value of your prescription drugs total $4,550 (2014 figure). However, as a result of the Affordable Care Act, this donut hole is shrinking, and the costs for retirees are subsidized by the government.

For 2014, this means that the retiree has to pay only 47.5 percent of all payments for brand-name drugs and 72 percent of the payment of generic drugs, while getting credit for 100 percent of the cost of those drugs until the total cost equals $4,550.[2] Once your annual prescription costs exceed $4,550, you're out of the donut hole. At this point you are responsible for $2.55/month for generic drugs and a $6.35 copayment on brand-name medications, or 5 percent of the medication's retail cost, whichever is higher.[3] You can find more about the donut hole at Medicare.gov.

THE DONUT HOLE EXPLAINED



Understanding your prescription drug needs is critical to knowing if and when you may enter the donut hole. Due to the changes under the Affordable Care Act, the coverage gap will be completely closed by 2020. There are many calculators that can help you create an accurate budget that addresses the donut hole, including one provided by AARP.

[1] U.S. Social Security Administration (https://secure.ssa.gov/poms.nsf/lnx/0601101020 | 11/5/13 - Present)
[2] Retiree's costs: http://medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html
[3] Donut hole graphic data http://www.q1medicare.com/PartD-PartDCoverageGapCalculator14Xphp.php

WHAT IS AND ISN'T COVERED BY MEDICARE

Medicare generally helps cover most of your important health care costs, like surgeries, doctors' appointments, and your maintenance or well-visit services. Always talk to your doctor or other care provider to verify whether Medicare covers whatever service or supply that is being recommended. You can also check whether a test, item, or service is covered using a search tool available on the Medicare website. Some of the common health care expenses covered by Medicare are summarized in the following chart.

WHAT IS COVERED?

PART A	PART B	PART D
• Hospital care (with eligibility requirements such as doctors' orders or the facility's acceptance of Medicare) • Skilled nursing facility care • Nursing home care (as long as custodial care isn't the only care you need) • Hospice (if you're terminally ill) • Home health services • Some lab tests • Surgeries	• Covers two types of services: Medically necessary doctors' services and supplies and preventive care • Clinical research • Ambulance services • Durable medical equipment • Mental health - Inpatient - Outpatient - Partial hospitalization • Some home health care • Getting a second opinion before surgery • Limited outpatient prescription drugs	Each Medicare prescription drug plan has its own list of covered drugs (called a formulary). Many Medicare drug plans place drugs into different "tiers" on their formularies. Drugs in each tier have a different cost. A drug in a lower tier will generally cost you less than a drug in a higher tier.

Source: http://www.medicare.gov/what-medicare-covers/index.html

WHAT ISN'T COVERED?

Many people are often surprised that Medicare does not offer vision or dental coverage. In addition, Medicare offers coverage only in the United States, which could be an issue for people considering vacationing or even retiring abroad. You'll always want to verify whether a medical item or service is covered by Medicare. Below we've highlighted some of the most common items not covered by Original Medicare:[1]

- Long-term care (also called custodial care)
- Routine dental care
- Routine eye care
- Cosmetic surgery
- Acupuncture
- Orthopedic shoes
- Dentures
- Hearing aids and related exams
- Routine foot care (corns, bunions, etc.)
- Care outside the United States

Medicare.gov offers a search feature to determine if your test, item, or service is covered. Additionally, some of these expenses can be covered through the use of a Medicare Advantage policy (Part C, discussed above) or a Medicare Supplement policy (discussed in the next section).

[1] Medicare.gov, what Medicare does not cover, http://www.medicare.gov/what-medicare-covers/not-covered/item-and-services-not-covered-by-part-a-and-b.html

ADDITIONAL COSTS

MEDICARE SUPPLEMENTAL (MEDIGAP) COVERAGE

Medigap insurance, sometimes referred to as Medicare supplemental insurance, is an insurance plan sold by private companies that can help pay for some of the health care costs that Original Medicare doesn't cover, such as copayments, coinsurance and deductibles. It's an optional program, but you must have Medicare Part A and B in order to purchase it.[1] If unknown out-of-pocket expenses are too unsettling for you or too costly, a Medigap plan may be a solution since it allows you to purchase additional coverage to "customize" your plan to your specific needs. There is an additional monthly premium for the Medigap coverage based on how you have designed your plan. Every Medigap policy must comply with federal and state laws, assuring that each of them will offer the same basic benefits within each standardized category, no matter which insurance company sells it. These standardized policies are identified by the letters A through N. Generally, Medigap policies do not cover long-term care, vision or dental care, hearing aids, eyeglasses, or private-duty nursing. If you are interested in learning more about Medicare supplemental insurance, we recommend you work with a licensed health care professional to help you identify the possible solutions aligned to your needs.

THE INCOME-RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA)

If you have higher income, you will pay higher premiums. Since 2007, higher-income Medicare beneficiaries enrolled in Part B pay a greater share of Part B costs.[2] Higher-income Medicare beneficiaries enrolled in Part D prescription drug plans are also required to pay higher Part D premiums as a result of changes made in the Affordable Care Act. The additional payments are called an Income-Related Monthly Adjustment Amount (IRMAA).

Below is a chart that shows, based on your income, how much more you might pay. An important point to note is that each year Medicare reviews your income (which includes 401(k) and IRA distributions) from two years prior. So, if you are turning 65 this year and are retired (possibly reporting less income than when you were working), Medicare, for the purposes of your premiums, is looking back two years (when your income may have been higher). For those who are interested in what they will need to pay in 2014, we've outlined the income ranges below. If your income on your 2012 tax return is above $85,000 if you're single or $170,000 if you're married, you will need to pay more. Here's the breakdown.

MONTHLY MEDICARE PREMIUM INCREASES BASED ON INCOME[3]				
FILE INDIVIDUAL TAX RETURN	FILE JOINT TAX RETURN	FILE MARRIED & SEPARATE TAX RETURN	PART B PREMIUM INCREASE (2014)	PART D PREMIUM INCREASE (2014)
$85,000 or Less	$170,000 or Less	$85,000 or Less	No Increase	No Increase
$85,001 to $107,000	$170,001 to $214,000	Not Applicable	+$42.00	+$12.10
$107,001 to $160,000	$214,001 to $320,000	Not Applicable	+$104.90	+$31.10
$160,001 to $214,000	$320,001 to $428,000	$85,001 to $129,000	+$167.80	+$50.20
Above $214,001	Above $428,001	Above $129,001	+$230.80	+$69.30

[1] Those on Medicare Advantage plans cannot purchase Medicare Supplement insurance. If you have a Medicare Advantage plan, you can apply for a Medigap policy, but make sure you can leave the Medicare Advantage plan before your Medigap policy begins.

[2] Medicare Modernization Act (MMA) of 2003.

[3] http://www.ssa.gov/pubs/EN-05-10536.pdf

PULLING IT ALL TOGETHER: JOHN AND ISABELL

Now that we've reviewed the various parts of Medicare, let's look at an example of the annual costs typically associated with a married couple on Medicare.

John and Isabell are both turning 65 next month and are planning to enroll in Medicare; both meet the eligibility requirements. Isabell is in good health and currently takes two monthly prescriptions, while John has had his share of medical issues. He takes several medications and has been hospitalized regularly in the past. Both have decided to enroll in Original Medicare and plan to purchase additional coverage through a Medicare supplemental plan. Because of his health history, John has chosen to enroll in a more comprehensive (and expensive) Medicare supplemental plan in comparison to Isabell. We have highlighted the estimated costs per month that John and Isabell would typically incur. It's important to note that even for this couple with no major illnesses or surgeries included in the example, the costs can quickly add up. Also, keep in mind that these costs do not include dental care, hearing aids, or vision care that is not covered under Medicare plans.

	JOHN	ISABELL
Part A	No Cost	No Cost
Part B	$105/Month[1]	$105/Month[1]
Part D	$40/Month[2]	$40/Month[2]
Medigap	$180/Month[2]	$140/Month[2]
Monthly Out-of-Pocket Estimate (Copays/Deductibles)	$100/Month	$50/Month
Total	$425/Month or $5,100/Annual Cost	$335/Month or $4,020/Annual Cost

* For illustrative purposes only; individual circumstances vary; other costs such as vision, dental, deductibles, etc. are not included.

Now, let's assume that John and Isabell are considered high-income beneficiaries under the Medicare rules, as their IRAs and other income streams total $200,000/year. That fact alone, without any additional medical expenses, would increase their annual out-of-pocket expenses by nearly $1,300/year, as each of their Part B and Part D premiums would increase. Medicare would increase each of their premiums by $42.00/month for Part B and $12.10/month for Part D ($42.00 x 2 x 12 months = $1,008 + $12.10 x 2 x 12 months = $290.40). This would increase John's annual out-of-pocket costs to $5,749.20/year and Isabell's annual out-of-pocket costs to $4,669.20/year.

[1] Medicare.gov, What Medicare Costs, http://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html and http://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html

[2] Medigap: Spotlight on Enrollment, Premiums, and Recent Trends; The Kaiser Family Foundation, April 2013

HOW WOULD A HEALTH EVENT IMPACT JOHN AND ISABELL'S HEALTH CARE COSTS?

Now let's look at another scenario of how some common accidents and illness could contribute to an increase in health care costs in any given year. In January, John suffered a fall and broke his hip and leg. He required surgery that kept him in the hospital for 15 days, and then he was transferred to a skilled nursing center for rehabilitation services. He spent an additional 60 days (two months) at the rehabilitation center, for a total care period of 75 days. Later that year in the winter, John came down with the flu, which put him back into the hospital for another four days. In this scenario, John, through Parts A and B alone, incurred the following costs. Although some costs may be covered through John's Medigap plan, we are not showing any financial support for them in this scenario since covered expenses are based solely on the type of plan selected.

ILLNESS	SERVICES	DAYS OF CARE	COSTS[1]
Broken Hip and Leg	Hospital Charges	1-15	$1,216 Deductible
	Skilled Nursing Rehab Center	15-60	$0 (Covered Through Initial Deductible of $1,216)
	Skilled Nursing Center ($304 Per Day Copayment)	61-75	$4,560
TOTAL COST FOR 1ST BENEFIT PERIOD			$5,776
Flu Hospital Visit	Hospital Charges	1-4	$1,216 (New Deductible)
TOTAL COST FOR 2ND BENEFIT PERIOD			$1,216
TOTAL COSTS IN ONE YEAR FOR BOTH BENEFIT PERIODS			$6,992 Additional Out-of-Pocket Expenses

* For illustrative purposes only; individual circumstances vary.

As you can see, there will be years when John and Isabell's health care expenses could be higher than estimated, and there will be years when their out-of-pocket expenses might be lower than estimated. But over their lifetimes, including these annual estimates in their retirement budget will better prepare them to meet their health care costs in retirement.

[1] Deductible, copayment, and coinsurance figures sourced from Medicare.gov (http://www.medicare.gov/coverage/inpatient-hospital-care.html)

HOW AND WHEN DO I ENROLL?

FIRST-TIME OPEN ENROLLMENT

As you approach your 65th birthday, you will want to begin the process of applying for Medicare or confirm that any current insurance you have allows you to delay enrolling. There is a very specific period of time when you are required to enroll for Medicare or provide proof that you are covered under another eligible plan. If you fail to do this, you will pay a penalty—a substantially increased monthly premium—for the entire duration of your coverage. This penalty increases cumulatively for each year you fail to enroll or provide proof of coverage.

The enrollment period is during the seven-month period that starts three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65. For example, if you turn 65 in October of 2014, your enrollment period is between July 2014 and January 2015.

If you are already collecting Social Security, in most cases you will be automatically enrolled in Medicare Parts A and B when you turn 65. However, more and more people are delaying taking Social Security because they are working beyond 65. If you are one of them, you have a few additional options. If you're covered under a qualified group health plan based on current employment (note that the employer must have 20 or more employees to qualify), you can continue to utilize your employer's insurance. If you're covered by a qualified group health care plan, you will have a special enrollment period to sign up for Part A and/or Part B when your coverage changes. Please note that COBRA and retiree health plans do not qualify as coverage under these rules. We recommend you work with a health insurance professional to evaluate your options for enrollment and which Medicare Parts will provide the best coverage for your needs.

BIRTH MONTH	ENROLLMENT PERIOD
January	October – April
February	November – May
March	December – June
April	January – July
May	February – August
June	March – September
July	April – October
August	May – November
September	June – December
October	July – January
November	August – February
December	September – March

If you are age 65, COBRA and retiree health plans do not qualify as coverage. You are still required to enroll for Medicare.

OPEN ENROLLMENT WHEN RECEIVING BENEFITS

After your initial plan enrollment, you can make changes to Medicare Parts B, C, and D only during a specific open-enrollment period, which runs from October 15 to December 7. Below we've outlined some of the changes you can make during this time; for a complete list visit Medicare.gov:

- Change from Medicare Parts A and B to a Medicare Advantage plan (Part C) or change from an Advantage plan back to Medicare Parts A and B.
- Switch between Medicare Advantage plans (Part C plans).[1]
- Join a Medicare prescription drug plan (Part D) or switch from one Part D plan to another plan.

[1] If you drop a Medigap/Supplemental insurance policy to switch to an Advantage plan, your future plan options could be impacted if your health changes. Contact a health care professional to understand the possible impacts of your choices before switching plans.

LATE ENROLLMENT PENALTY

As we discussed earlier, you are required to enroll for Medicare Parts B and D and if you don't sign up for Medicare when you're eligible, you could be assessed a late enrollment penalty. For Part B, if you don't sign up when you are eligible or if you drop Part B and then get it later, your monthly premium could go up as much as 10 percent for each 12 months that you could have had Part B and didn't sign up.

Additionally, there is a required window for when you must sign up for Part D. If you do not sign up for Part D within 63 days of being eligible or do not have coverage through another creditable prescription drug program, you may have to pay a late enrollment penalty for as long as you have Medicare. The penalty is based on how long you went without a creditable prescription drug plan. The late enrollment penalty is calculated by multiplying 1 percent of the "national base beneficiary premium" ($32.42 in 2014) times the number of full, uncovered months you were eligible but didn't join a Medicare prescription drug plan. To obtain more details on the calculation of the penalty, visit Medicare.gov.

SOME FINAL CONSIDERATIONS

MEDICARE AND HEALTH SAVINGS ACCOUNTS (HSAs)

When you enroll in Medicare, you can no longer contribute to your Health Savings Account (HSA). This catches some older workers by surprise (especially if the worker has applied for Social Security, which automatically enrolls you in Medicare when you turn 65). You will be allowed to withdraw money from an existing HSA after enrollment to help pay for medical expenses you are responsible for, such as premiums and copays; however, you won't be allowed to add or contribute to it going forward. As always with an HSA, qualified medical expenses continue to be tax free.

A NOTE ABOUT LONG-TERM CARE COVERAGE

After age 65, Americans have more than a 70 percent chance of needing some form of long-term care.[1] While Medicare will help pay for short-term stays in a skilled nursing facility, it does not pay for long-term custodial care such as might be needed for Alzheimer's or other permanently incapacitating illnesses. Medicare will pay for up to 100 days in a skilled care facility per incident, but you have to be properly admitted to a hospital for the three days prior (not for observation). If not properly admitted, the 100 days will not be covered (learn more here), and there is no out-of-pocket maximum for these costs. Medicaid, which is a public assistance program, does cover the majority of the expense of long-term care, but to qualify you must meet minimum state eligibility requirements and your income must be below a certain level.

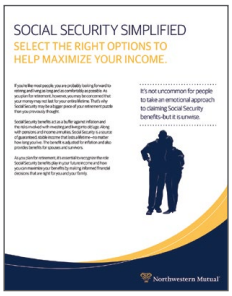
[1] US Department of Health and Human Resources, LongTermCare.gov

SUMMARY

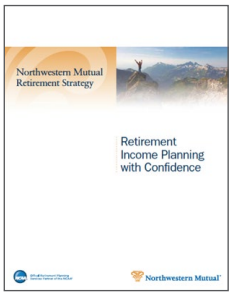
If you are planning for retirement or are approaching retirement, there are two key steps we recommend you take. First, be sure you understand the impact of health care expenses on your current retirement income strategy. Northwestern Mutual financial professionals have the tools necessary to evaluate your current retirement plan and can show you how your plan could be affected by health care costs in retirement. They can also identify strategies designed to help you plan for the increasing cost of health care.

Second, we suggest you work with a credible health insurance professional who can understand your specific situation and the needs you'll have (international travel, certain drug coverage, etc.) to help you identify the best Medicare options to address your needs. Your financial professional can help connect you with someone and will collaborate with him or her to better ensure the decisions made are based both on your desires for health care coverage and your budget.

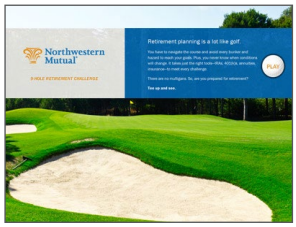
ADDITIONAL RESOURCES TO HELP YOU NAVIGATE RETIREMENT



Discover How to Maximize Your Social Security Benefit with Our Guide



Learn More About Our Retirement Strategy



Take the 9-Hole Challenge to See How Prepared You Are for Retirement

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