Social Security and Medicare

DSMT-2011
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You are asked to read the material and, during the course, to test your comprehension of each of the learning objectives by answering self-study quiz questions. After completing each quiz, you can evaluate your progress by comparing your answers to both the correct and incorrect answers and the reason for each. References are also cited so you can go back to the text where the topic is discussed in detail. Once you are satisfied that you understand the material, answer the examination questions which follow each lesson and record your answer choices by logging on to our Online Grading System.

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examination. A certificate documenting the CPE credits will be issued for each examination score of 70% or higher.

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Social Security and Medicare (DSMTG11)

OVERVIEW

COURSE DESCRIPTION: This interactive self-study course provides the latest information on Social Security and disability benefits available to workers and their families, as well as Medicare requirements, costs and coverage.

PUBLICATION/REVISION DATE: March 2011

PREREQUISITE/ADVANCE PREPARATION: Basic knowledge of taxation

CPE CREDIT: 6 QAS Hours, 6 Registry Hours

CTEC CREDIT: 6 Federal CTEC Hours, 0 California Hours

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CFP® CREDIT: 3 CE Hours – CFP® credit hours are one half the number of CPE credit hours.

FIELD OF STUDY: Taxes

EXPIRATION DATE: March 31, 2012

KNOWLEDGE LEVEL: Basic
LEARNING OBJECTIVES

Lesson 1: Eligibility for Retirement Benefits
Completion of this lesson will enable you to:
  • Identify the requirements for employee eligibility and what constitutes wages for Social Security purposes.

Lesson 2: Retirement Benefits for Workers
Completion of this lesson will enable you to:
  • Describe, in general, various aspects of retirement benefits for workers provided by the Social Security Act including, but not limited to, eligibility, filing an application, retroactive benefits, excess earnings, and the earnings test.

Lesson 3: Retirement Benefits for Families
Completion of this lesson will enable you to:
  • Identify the basic requirements for spousal benefits, children’s benefits, and the maximum family benefit.

Lesson 4: Planning Considerations
Completion of this lesson will enable you to:
  • Determine the advantages of taking Social Security benefits at various ages, the point at which Social Security benefits become taxable, and various strategies for dealing with possible taxation of benefits.

Lesson 5: Survivor’s and Disability Benefits
Completion of this lesson will enable you to:
  • Identify various survivor benefits and their qualification requirements, as well as disability benefits and their eligibility requirements.

Lesson 6: Medicare
Completion of this lesson will enable you to:
  • Identify the various parts of Medicare and explain the eligibility requirements and coverage options.

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TAX & ACCOUNTING

CINS020
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Lesson 1: Eligibility for Retirement Benefits

Learning Objectives

Completion of this lesson will enable you to:

- Identify the requirements for employee eligibility and what constitutes wages for Social Security purposes.

Background

An individual qualifies for Social Security benefits based on credits earned while working. These credits are based on the individual’s amount of earnings. The worker’s eligibility for retirement, disability and survivor’s benefits is based on the credits earned over his work history.

Earning Credits

Amount of Credit

In 2011, taxpayers receive one credit for each $1,120 of earnings, up to a maximum of four credits per year.

The amount of earnings needed for credits increases annually and is based on the increase of the average national earnings level. The credits earned by taxpayers remain on their Social Security record even if they change jobs or cease to have earnings.

Quarterly Earnings Not Required

While a maximum of four credits can be earned in a year, the earnings for that year can be earned in any quarter. For example if a worker earns $4,480 in the first two months of 2011, he receives four credits (4 × $1,120) for 2011.

Number of Credits Needed

Anyone born in 1929 or later needs 10 years of work (40 credits) to be eligible for retirement benefits.

Who Are Employees?

For Social Security purposes, workers are considered employees if:

- They are an officer of a corporation;
- They meet the common-law test; or
- They are in one of the four specific occupations described under “Statutory Employees” later in this lesson.
Corporate Officers

- Corporate officers are normally considered employees of the corporation. [Those who perform the duties of an officer are statutory employees for FWT, FICA and FUTA under Code Sec. 3121(d)(12), 3306(i) and 3401(c).]
- Directors of a corporation are self-employed for any services performed as directors.
- If a Director provides services outside the role of Director, he is considered an employee for those services.
- S corporation officers and employee-shareholders are considered employees. Compensation for their services must be paid as wages.

Partners in a Partnership

Partners generally are not employees of either the partnership or any of the partners of the business. However, a partnership can be classified as a corporation if it meets conditions 1–5 below. If a partnership can be classified as a corporation, partners who perform duties similar to those of officers of a corporation are considered employees.

1. Management is centralized—a certain number of associates, acting as a board of directors, controls the association regarding how business is conducted;
2. The organization continues uninterrupted upon the death of an owner or a change in share ownership;
3. The organization’s members have the absolute right to dispose of their interests in the organization;
4. The organization intends to continue growing as a business; and
5. No associate is personally liable for debts incurred that exceed the organization’s assets.

Common-law Test

Under the common-law test, 20 factors are used to evaluate the extent of control the employer has over the worker. The focus of the test is on the business’s legal right to control the worker and his performance. Workers employed by businesses that have the right to exert a high degree of control over the behavior of the worker will be normally considered employees.

Practitioners should focus their analysis on the legal right of control the employer has over the worker in applying these tests. Workers can still be considered employees even in situations where the employer has the right but chooses not to exercise control over the worker.

It is possible that a worker who meets the common-law test can still be legally classified as a subcontractor for employment tax purposes.

Twenty Factors

The factors, or elements, that show control over the worker are discussed in the “Worker Status—Twenty Factors” table in the Appendix. These factors have to be weighed in determining the worker’s status. It is important to note that any single factor or group of factors taken together is not necessarily evidence of control. Determining evidence of control is based on a careful evaluation of all facts collectively.
The weight or amount of importance given to each factor varies depending on the type of business and the services rendered. In evaluating professional occupations such as with physicians, lawyers and accountants, more weight should be given to such factors as the opportunity to make a profit. Behavioral controls might be given greater weight in other situations.

According to the IRS, all information that provides evidence of the degree of control and independence must be considered in determining whether the worker is an employee or an independent contractor. Facts that provide evidence of the degree of control and independence fall into three categories shown in the following table.

<table>
<thead>
<tr>
<th>IRS Summary of Common-law Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Control</td>
</tr>
<tr>
<td>Factors that illustrate whether there is a right to direct or control how the worker performs the specific task for which he is engaged fall into the categories of:</td>
</tr>
<tr>
<td>• Type of instructions,</td>
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<td>• Degree of instruction,</td>
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<tr>
<td>• Evaluation systems, and</td>
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<tr>
<td>• Training.</td>
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<tr>
<td>Financial Control</td>
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<tr>
<td>Factors that illustrate whether there is a right to direct or control how the business aspects of the worker’s activities are conducted fall into the categories of:</td>
</tr>
<tr>
<td>• Significant investment,</td>
</tr>
<tr>
<td>• Unreimbursed expenses,</td>
</tr>
<tr>
<td>• Services available to the relevant market,</td>
</tr>
<tr>
<td>• Method of payment, and</td>
</tr>
<tr>
<td>• Opportunity for profit or loss.</td>
</tr>
<tr>
<td>Relationship of the Parties</td>
</tr>
<tr>
<td>Factors that illustrate how the parties perceive their relationship fall into the categories of:</td>
</tr>
<tr>
<td>• Intent of parties/written contracts,</td>
</tr>
<tr>
<td>• Employee benefits,</td>
</tr>
<tr>
<td>• Discharge/termination, and</td>
</tr>
<tr>
<td>• Regular business activity.</td>
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</tbody>
</table>

Statutory Employees

A worker in one of the four occupational groups set out in this section is an employee for Social Security purposes, even if he does not meet the common-law test as long as:

1. The work contract expects the worker will do most or all of the work;
2. He has no substantial investment in the facilities used to do the work (except for tools, equipment, transportation or clothing employees usually provide); and
3. There is an ongoing work relationship with the employer.

The contract of service may be oral or written. Of prime importance is the intention that the worker performs the essential services of the job. Normally, the contract is written in such a way that the worker lacks the authority to delegate a substantial portion of the work to another person. However, there are cases where a worker might occasionally hire a substitute or assistant and still be an employee under this test.
A substantial investment in facilities includes the investment in items such as office furniture, fixtures, premises and machinery. A salesperson who maintains a home office may not have substantial investment; however, a salesperson with an office elsewhere would be considered to have a substantial investment in facilities.

An investment in education, training, tools, instruments, clothes or vehicles (used to go to and from work) is not considered a substantial investment in facilities.

A worker has an ongoing work relationship if he works regularly and frequently for the employer. Regular part-time work and regular seasonal work are considered ongoing. On the other hand, a single job transaction, even if it covers a considerable period of time, is not usually part of an ongoing relationship.

**Agent-drivers or commission-drivers.** If the requirements in the previous column are met by a worker who distributes any of the following items, he is considered a statutory employee:

1. Meat or meat products,
2. Vegetables or vegetable products,
3. Fruit or fruit products,
4. Bakery products,
5. Beverages (other than milk), or
6. Laundry or dry cleaned clothing.

A worker must perform the services for the individual engaging him to be considered an employee. If he buys merchandise on his own behalf and sells it to the public as part of his own independent business, he is not considered an employee. In addition, if he distributes items that are not incidental to handling items 1–6 above, he is not considered an employee.

Several factors do not affect the employee’s status as an agent-driver or commission-driver:

1. He may sell at wholesale or retail;
2. He may operate from his own truck or from a company truck;
3. He may serve customers designated by the company or solicit his own;
4. He may distribute other products provided that the handling of these products is incidental to the handling of items 1–6 above; and
5. He may be compensated in any manner. How he is compensated is immaterial.

**Full-time life insurance salespersons.** Workers are considered to be statutory employees if they:

1. Meet the requirements above;
2. Solicit life insurance or annuity contracts as their entire or principal business activity; and
3. Work primarily for one life insurance company.

Employees should be provided with office space, stenographic help, telephone facilities, forms, rate books and advertising materials by the company or a general agent.
Generally, the employment contract reflects the intention of the worker and the company regarding full-time work. The actual time spent working is not important. What is important is the contractual intent of full-time work. A worker may work regularly only a few hours a day yet still qualify as a full-time life insurance salesperson if the contract intends that the worker engage in full-time activity.

A principal business activity takes the major part of a salesperson’s working time and attention. This means that the worker’s efforts must be devoted primarily to the solicitation of life insurance or annuity contracts. Occasional or incidental sales of other types of insurance (for example, surplus-line insurance) do not affect this requirement. On the other hand, if a worker is required to work substantially on selling applications for insurance contracts other than life insurance (for example, health, accident, fire, etc.), they do not meet the requirement.

**Full-time traveling or city salespersons.** Workers are considered statutory employees if they:

1. Meet the requirements above;
2. Solicit orders for merchandise on behalf of another person or firm as their principal activity;
3. Obtain their orders from businesses whose primary function is the furnishing of food and/or lodging (for example, wholesalers, retailers, contractors and hotel and restaurant operators); and
4. Sell merchandise that is bought for resale or used as supplies in the customer’s business operations.

Full-time means that the worker works primarily for one person or business. It does not matter how much time they spend on the job.

Manufacturers, representatives and multiple-line salespersons who work for a number of firms are usually not considered employees.

**Homeworkers.** Workers are considered statutory employees if they:

1. Meet the requirements above;
2. Work away from the employer’s place of business;
3. Work according to their employer’s guidelines;
4. Work on materials or goods provided by the employer; and
5. Return the finished product to the employer or to someone whom the employer designates.

Homeworkers include individuals who make quilts, buttons, globes, bedspreads, clothing, needlecraft products, etc. Homeworkers usually work in their own homes or in a workshop away from their employer’s business. The type of work homeworkers do is usually simple and consists of following patterns or samples provided by the employer.

If workers receive wages less than $100 in a calendar year (the cash-pay test) from their employer, their pay is not counted for Social Security purposes. However, all of their pay is counted in applying the earnings test to a beneficiary, even if they do not meet the cash-pay test. If workers do not meet the cash-pay test, all of their pay is counted for benefits and the earnings test.
Maximum Earnings

In order to be eligible to receive Social Security benefits, workers must achieve the minimum number of credits discussed previously under “Earning Credits.” There is a maximum amount of earnings, however, which qualify in computing the amount of benefit.

For years after 1981, the maximum wage amount can be increased either by Congress or automatically, based on the cost of living. If Congress does not increase the maximum amount, it is automatically increased in multiples of $300 if there is a cost-of-living increase in Social Security benefits. The increased amount is officially published in the Federal Register on or before November 1 of the year before it goes into effect.

What Work Counts

Not all employees work in jobs covered by Social Security. Examples of employees not covered include:

- Most federal employees hired before 1984 (since January 1, 1983, all federal employees have paid the Medicare hospital insurance portion of the Social Security tax);
- Railroad employees with more than 10 years of service;
- Employees of some state and local governments that chose not to participate in Social Security; or
- Children younger than age 21 who do household chores for a parent. Children under the age of 18, employed in a family business operated as a sole proprietorship, are also excluded.

Wages for Social Security Purposes

Wages are all payments the worker receives for the performance of services for the employer. Wages do not have to be paid in cash. The cash value of all compensation paid to the worker in any form other than cash is also considered wages (unless the form of payment is specifically not covered under the Social Security Act).

### Wages for Social Security Purposes

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<th>Wages</th>
<th>Not Wages</th>
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<tbody>
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<td>• Capital gains</td>
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<td>• Commissions</td>
<td>• Gifts</td>
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<tr>
<td>• Fees</td>
<td>• Inheritances</td>
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<tr>
<td>• Vacation pay</td>
<td>• Investment income</td>
</tr>
<tr>
<td>• Cash tips of $20 or more a month</td>
<td>• Jury duty pay</td>
</tr>
<tr>
<td>• Severance pay</td>
<td>• Cafeteria plan benefits, unless cash is received instead of selected benefits</td>
</tr>
<tr>
<td>• Back pay</td>
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</tbody>
</table>
Social Security and Medicare

<table>
<thead>
<tr>
<th>Wages</th>
<th>Not Wages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expense reimbursements if:</td>
<td>• Prizes and awards received from persons other than the employer</td>
</tr>
<tr>
<td>• Employer does not require verification, or</td>
<td>• Damages, attorney fees, interest or penalties under court judgment or by compromise settlement based on wage claim</td>
</tr>
<tr>
<td>• Employee can keep amounts in excess of verifiable expenses.</td>
<td>• Payments to secure release of an unexpired contract of employment</td>
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<tr>
<td></td>
<td>• Pensions and retirement pay</td>
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<td>• Sick pay if paid more than six months after the employee last worked</td>
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<td>• Rental income, interest and dividends</td>
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<td></td>
<td>• Disability payments if:</td>
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<tr>
<td></td>
<td>• Entitled to disability before the year in which payment is made, and</td>
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<tr>
<td></td>
<td>• No work is performed for the employer during the pay period in which payment is made.</td>
</tr>
</tbody>
</table>

Wages are considered paid when:

- Actually paid in form of cash, check, bank deposit or similar form other than cash.
- Constructively paid:
  - Credited or set aside, and can be accessed at any time.
  - Employer intends to pay, set apart or credit the wages, and is able to do so, but fails to do so because of a clerical error or mistake in the mechanics of payment.
  - Payment is delayed at the request of the employee.

**Cash-pay Tests**

If workers receive wages less than $100 in a calendar year (the cash-pay test) from their employer, their pay is not counted for Social Security purposes. However, all of their pay is counted in applying the earnings test to a beneficiary, even if they do not meet the cash-pay tests.

In figuring wages, workers must meet the cash-pay tests if they perform any of the following types of work:

1. Agricultural labor
2. Domestic service in a private home
3. Nonbusiness or casual labor
4. Some services by homeworkers
5. Tips

If a worker meets the cash-pay test, he must count all cash as his wages. Homeworkers meeting the test must count both cash and payments-in-kind. In-kind payments are not counted as wages for workers described in 1, 2, 3 or 5 above, even they meet the cash-pay test.
If a worker does not meet the cash-pay test, payment is not counted as wages for Social Security purposes, even if it is paid in cash. A worker must count all cash pay (except tips that total less than $20) to apply the earnings test.

Cash pay for cash-pay tests includes the following:

1. Cash;
2. Checks and other monetary forms of exchange;
3. The income received as an employee from the sale of a crop from the farm owner/operator; and
4. Cash given in place of such items as meals, lodging, car tokens, clothing, etc.

Cash pay for cash-pay tests does not include the following:

1. Payments-in-kind, such as meals and lodging;
2. A share of crops or animal increase;
3. Car tokens, clothing, transportation passes or tickets; and
4. The furnishing of goods or limited credit made available at a store for the maintenance of the worker and family.

**Wages paid after death.** Wages earned before death and paid to a survivor or the employee’s estate after death count as wages if they are paid in the calendar year the worker died.

If the wages are paid after the calendar year that the worker died, they do not count as wages. In addition, they are not subject to FICA contributions.

**Household Employees**

Domestic service in the private home of the employer is covered by Social Security beginning January 1, 1951. However, cash and noncash remuneration is excluded from wages unless a regularity-of-employment and cash-pay test are met. Prior to 1994, only cash pay paid to the domestic worker in the calendar quarter by the employer amounting to $50 or more counted for Social Security purposes.

Beginning in 1994, rules for coverage of domestic services performed in the private home changed. Once the employer pays the minimum amount as shown in the following table, the wages are subject to Social Security and Medicare taxes. For 2010, if the employer pays $1,700 or more, the wages are subject to both Social Security and Medicare taxes.

<table>
<thead>
<tr>
<th>Year</th>
<th>Minimum Pay</th>
<th>Year</th>
<th>Minimum Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994–1997</td>
<td>$1,000</td>
<td>2006–2007</td>
<td>$1,500</td>
</tr>
<tr>
<td>1998–1999</td>
<td>1,100</td>
<td>2008</td>
<td>1,600</td>
</tr>
<tr>
<td>2000</td>
<td>1,200</td>
<td>2009</td>
<td>1,700</td>
</tr>
<tr>
<td>2001–2002</td>
<td>1,300</td>
<td>2010</td>
<td>1,700</td>
</tr>
<tr>
<td>2003–2005</td>
<td>1,400</td>
<td>2011</td>
<td>1,700</td>
</tr>
</tbody>
</table>
For calendar years after 1998, the earnings threshold is adjusted in multiples of $100 in a given year, as average wages adjust.

Beginning in 1995, services are excluded from Social Security coverage for work done in a private home by an employee who is under 18 years old at any time of the year, provided the services are not the employee’s principal occupation.

**Self-employed**

Most self-employed individuals became covered by Social Security in 1951.

**Trade or Business**

For Social Security purposes, the term trade or business has the same meaning as when used in Section 162 of the Internal Revenue Code relating to income taxes. Certain occupations and the self-employed activities of members of certain religious groups who have been granted exemptions from the self-employment tax are not included in the term trade or business for Social Security purposes. They are included only if certain conditions are met.

**Guidelines for Trade or Business**

Trade or business is not specifically defined in IRC Section 162; however, certain guidelines for deciding whether a trade or business exists have been set forth in court decisions and IRS rulings. Briefly stated, these guidelines are:

1. The worker started and carried on the activity in good faith with the intention of making a profit or producing income;

2. The worker carried on the activity regularly, with a continuity of operation, a continual repetition of transactions or a regularity of activities;

3. The activity is the regular occupation or calling that was carried on to make a living or a profit; and

4. The worker presents himself to the public as being engaged in the selling of goods and/or services.

Any one of these factors standing alone is not enough to show that a trade or business exists, but not all the factors need be present.

**Personal services not required.** An individual may carry on a business through employees. Thus, absentee owners or silent partners can derive income from a trade or business.

**Limited partners.** For taxable years beginning after 1977, limited partners are excluded from Social Security coverage. Previously, limited partners could be covered on the same basis as other partners.
Length of time in business. The length of time engaged in an activity usually is a factor in determining if it is a trade or business. If the activity is seasonal or of short duration, however, the period of time is not important.

For example, selling ice cream during the summer months or owning a grocery store for a short time before selling it are situations where the short time period would not prevent the activity from being covered by Social Security.

Illegal activities. The illegality of an activity does not prevent it from being a trade or business. For example, professional gamblers, bookies, etc. may be engaged in a trade or business. If workers are in this category, they are considered self-employed and are required to report their income and pay self-employment taxes.

More than one business. An individual may own more than one trade or business. For example, they may operate both a wholesale grocery and a restaurant.

Hobbies. A hobby is not generally a trade or business. If an individual buys and sells stamps, pigeons or coins to further the hobby rather than to make a profit, the activity is not a trade or business. If the individual conducts these activities to provide part or all of his livelihood, they may be a trade or business.

Consideration of the guidelines above, in combination with the facts in each case, determines whether the activity is a trade or a business.
SELF-STUDY QUIZ

Determine the best answer for each question below. Then check your answers with the correct answers in the following section.

1. Which of the following would be considered a statutory employee for Wishbone Industries?
   a. Sally is an accounts payable clerk for Wishbone Industries. She works part-time and completes her job by following an accounts payable manual provided by the company.
   b. Steve is the controller of Wishbone Industries and is legally designated as a corporate officer of the company.
   c. Henry is a sales representative of Wishbone Industries. He works solely on commission and currently works for numerous companies as a sales representative.
   d. Stephanie currently produces products for Wishbone Industries from her home. Each Monday, she goes to the company, picks up her materials and instructions, completes the work at home and then returns it each Friday to the company.

2. Which of the following is considered wages for purposes of qualifying for Social Security?
   a. Drew worked on commission for Greenhouse Products. Drew passed away in 2010. His final commission check was sent to his surviving spouse in February 2011.
   b. Libby works for Hobson Industries. For the last two weeks, Libby has been out of work at jury duty. She earned $25 per day at jury duty. Her employer does not require her to give her earnings to the company.
   c. John was terminated from Sphere Line Products due to sale of the company to a competitor. He was given six months of wages as a severance package upon his termination.
   d. Mackenzie, age 16, works for her dad, a sole proprietor, each afternoon filing papers. He pays her $100 per week for her services.

3. Alex is a full-time student who provides domestic services to an elderly couple in their private home. Which of the choices below will allow Alex’s employer to avoid the payment of Social Security taxes on the wages paid to Alex?
   a. Alex is 17 years old in 2011 and earns $1,600.
   b. Alex is paid at least $1,700 for his service in 2008.
   c. Alex is paid at least $1,800 for his service during 2010.
   d. Alex is 21 years old in 2011 and earns $1,700.
4. A trade or business is defined in the same way for Social Security purposes as it is for income taxes per Section 162 of the Internal Revenue Code. Which of the following would not be considered a trade or business in relation to Social Security?

a. Sam is a professional gambler. He makes his living by following the poker circuit and playing cards for a profit.

b. Mark collects coins in a company, Rare Finds. He continually buys and sells rare coins in his collection. The profit that he makes off the sale of his coins is used to purchase more items for his collection.

c. Libby owns a snow cone stand that she opens and runs each summer when she is home from college. The stand is open only about eight weeks per year.

d. Susan decided to start a company creating custom dresses for little girls. She intended for the company to generate a profit and worked at the process all year, but the company failed to show a profit.
SELF-STUDY ANSWERS

This section provides the correct answers to the self-study quiz. If you answered a question incorrectly, reread the appropriate material in this lesson. (References are in parentheses.)

1. Which of the following would be considered a statutory employee for Wishbone Industries? (Page 5)

   a. Sally is an accounts payable clerk for Wishbone Industries. She works part-time and completes her job by following an accounts payable manual provided by the company. [This answer is incorrect. Sally would be considered an employee, but not a statutory employee. She meets the qualifications of an employee under the common-law test for behavioral control, since Wishbone Industries controls how Sally completes her task by providing instructions. It does not matter that she is a part-time employee.]

   b. Steve is the controller of Wishbone Industries and is legally designated as a corporate officer of the company. [This answer is incorrect. Corporate officers are normally considered employees of the corporation, rather than statutory employees.]

   c. Henry is a sales representative of Wishbone Industries. He works solely on commission and currently works for numerous companies as a sales representative. [This answer is incorrect. Henry is not considered an employee or a statutory employee of Wishbone Industries. Manufacturers, representatives and multiple-line salespersons who work for a number of firms are usually not considered employees.]

   d. Stephanie currently produces products for Wishbone Industries from her home. Each Monday, she goes to the company, picks up her materials and instructions, completes the work at home and then returns it each Friday to the company. [This answer is correct. Stephanie would be considered a statutory employee, included in one of the four occupational groups of statutory employees. She would be included in the homeworkers group, since she works away from the employer’s place of business, works according to the employer’s guidelines using the materials provided by the employer, and then returns the finished product to the employer.]

2. Which of the following is considered wages for purposes of qualifying for Social Security? (Page 6)

   a. Drew worked on commission for Greenhouse Products. Drew passed away in 2010. His final commission check was sent to his surviving spouse in February 2011. [This answer is incorrect. Wages earned before death and paid to a survivor or the employee’s estate after death count as wages if they are paid in the calendar year the worker died. If the wages are paid after the calendar year that the worker died, they do not count as wages.]

   b. Libby works for Hobson Industries. For the last two weeks, Libby has been out of work at jury duty. She earned $25 per day at jury duty. Her employer does not require her to give her earnings to the company. [This answer is incorrect. According to the Social Security Act, jury duty pay is not considered wages for Social Security purposes.]
c. John was terminated from Sphere Line Products due to sale of the company to a competitor. He was given six months of wages as a severance package upon his termination. [This answer is correct. Severance pay is deemed wages by the Social Security Act and will be included in his annual wages for Social Security purposes.]

d. Mackenzie, age 16, works for her dad, a sole proprietor, each afternoon filing papers. He pays her $100 per week for her services. [This answer is incorrect. Mackenzie’s wages would not be included for Social Security purposes because children under the age of 18 who are employed in a family business that is operated as a sole proprietorship are excluded from Social Security per the Social Security Act.]

3. Alex is a full-time student who provides domestic services to an elderly couple in their private home. Which of the choices below will allow Alex’s employer to avoid the payment of Social Security taxes on the wages paid to Alex? (Page 8)

a. Alex is 17 years old in 2011 and earns $1,600. [This answer is correct. Since Alex is a full-time student, the household service he provides is not considered to be his principal occupation and the services are excluded from Social Security coverage.]

b. Alex is paid at least $1,700 for his service in 2008. [This answer is incorrect. For the year 2008, wages in excess of $1,600 are subject to Social Security tax.]

c. Alex is paid at least $1,800 for his service during 2010. [This answer is incorrect. For the year 2010, wages in excess of $1,700 are subject to both Social Security and Medicare taxes.]

d. Alex is 21 years old in 2011 and earns $1,700. [This answer is incorrect. Services by an employee age 21 would not be excluded from Social Security taxes.]

4. A trade or business is defined in the same way for Social Security purposes as it is for income taxes per Section 162 of the Internal Revenue Code. Which of the following would not be considered a trade or business in relation to Social Security? (Pages 9-10)

a. Sam is a professional gambler. He makes his living by following the poker circuit and playing cards for a profit. [This answer is incorrect. The legality of an activity does not prevent it from being a trade or business. For example, professional gamblers may be engaged in a trade or business and be considered self-employed.]

b. Mark collects coins in a company, Rare Finds. He continually buys and sells rare coins in his collection. The profit that he makes off the sale of his coins is used to purchase more items for his collection. [This answer is correct. A hobby is not generally a trade or business. If an individual uses funds to further a hobby rather than to make a profit, the activity is not a trade or business.]

c. Libby owns a snow cone stand that she opens and runs each summer when she is home from college. The stand is open only about eight weeks per year. [This answer is incorrect. While the length of time engaged in an activity is a factor in determining
if it is a trade or business, the period of time is not important if the activity is seasonal. A seasonal activity would be considered a trade or business.]

d. Susan decided to start a company creating custom dresses for little girls. She intended for the company to generate a profit and worked at the process all year, but the company failed to show a profit. [This answer is incorrect. Since Susan started and carried on the activity in good faith with the intention of making a profit, carried on the activity regularly, and presented herself to the public as being engaged in selling custom dresses, her company would be considered a trade or business.]
EXAMINATION FOR CPE CREDIT

Lesson 1

Determine the best answer for each question below, then log onto our Online Grading System at cl.thomsonreuters.com/ogs to record your answers.

1. What are Social Security benefits based on for a taxpayer who is retiring?
   a. The years of service the taxpayer worked for his/her employer.
   b. The amount of money the taxpayer earned while working.
   c. The number of dependents the taxpayer is currently claiming.
   d. Do not select this answer choice.

2. For the calendar year 2011, what is the dollar amount of one credit a taxpayer can earn towards Social Security benefits?
   a. $1,000.
   b. $1,040.
   c. $1,090.
   d. $1,120.

3. Which of the following workers of the company would not be considered an employee, for Social Security purposes?
   a. Isabelle is a partner in Black & Brown, a local law firm.
   b. Hugh is a full-time salesperson for Alltime Insurance Agency.
   c. Rob is the CFO of Homefront Builders, Inc.
   d. Sarah is the payroll administrator of Highbrow Products, Inc.

4. If a worker meets the cash-pay test for payment for services rendered, the worker must count all cash as their wages. Which of the following would count as cash per the cash-pay test?
   a. Carlos works each evening at a local grocery store as a janitor in exchange for a set amount of groceries.
   b. Jimmy worked for a local farmer harvesting the wheat crop. He was paid a portion of the funds received from the mill once the crop was delivered.
   c. Matthew is working after school cleaning stalls at a local ranch. In exchange, he will be given one of the new foals when they are born in the spring.
   d. Cynthia is working at a summer camp in exchange for the use of an apartment that the camp owner has where she goes to college.
Lesson 2: Retirement Benefits for Workers

Learning Objectives

Completion of this lesson will enable you to:

- Describe, in general, various aspects of retirement benefits for workers provided by the Social Security Act including, but not limited to, eligibility, filing an application, benefit amount, retroactive benefits, excess earnings, and the earnings test.

Retirement Benefits Overview

The earliest a retiree can receive cash retirement benefits is at age 62. If a retiree elects to receive the retirement benefit before his normal retirement age, his benefit will be reduced for each month he retires early. The reduction is a permanent reduction and is also applied to all auxiliary benefits paid to members of the individual’s family. This reduced benefit continues to be paid even after the individual reaches full retirement age. In addition to the benefit reduction, the early retiree is subjected to an earnings test in which benefits can be further reduced if he earns more than the exempt amount. (See “Earnings Test” later in this lesson.)

There is no reduction for an individual who starts receiving the retirement benefit at full retirement age. As originally designed, full retirement age was age 65. However, under the 1983 amendments to Social Security, the full retirement age (FRA) has been slowly increasing for those born after 1937. While the age for Social Security retirement has been raised, the age to start receiving Medicare remains age 65.

Individuals who choose to defer or delay their retirement beyond full retirement age receive an additional credit for each month they do not receive benefits after attaining full retirement age but before age 70.

All retirement insurance benefits are based on the primary insurance amount. In some cases, a special minimum benefit is provided for some individuals as explained below. These amounts normally increase annually based on the cost-of-living benefit increase.

Additional monthly benefits, called auxiliary benefits, may be payable to other individuals, such as the spouse or children, based on the worker’s earnings record. These auxiliary benefits may also be payable on the worker’s earnings record if he is entitled to a disability insurance benefit.

Annually, the SSA mails a Social Security statement to everyone who is at least 25 years of age and not already receiving Social Security benefits. These statements are mailed three months before the person’s birthday.

All retirement benefits cease with the death of the recipient.
Full Retirement Age

Workers and Spouses Born after 1937

The chart that follows contains the full retirement age (FRA) for workers and spouses born after 1937.

<table>
<thead>
<tr>
<th>Birth Date</th>
<th>Full Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2/38–1/1/39</td>
<td>65 years and 2 months</td>
</tr>
<tr>
<td>1/2/39–1/1/40</td>
<td>65 years and 4 months</td>
</tr>
<tr>
<td>1/2/40–1/1/41</td>
<td>65 years and 6 months</td>
</tr>
<tr>
<td>1/2/41–1/1/42</td>
<td>65 years and 8 months</td>
</tr>
<tr>
<td>1/2/42–1/1/43</td>
<td>65 years and 10 months</td>
</tr>
<tr>
<td>1/2/43–1/1/55</td>
<td>66 years</td>
</tr>
<tr>
<td>1/2/55–1/1/56</td>
<td>66 years and 2 months</td>
</tr>
<tr>
<td>1/2/56–1/1/57</td>
<td>66 years and 4 months</td>
</tr>
<tr>
<td>1/2/57–1/1/58</td>
<td>66 years and 6 months</td>
</tr>
<tr>
<td>1/2/58–1/1/59</td>
<td>66 years and 8 months</td>
</tr>
<tr>
<td>1/2/59–1/1/60</td>
<td>66 years and 10 months</td>
</tr>
<tr>
<td>1/2/60 and later</td>
<td>67 years</td>
</tr>
</tbody>
</table>

Early Retirement

Beneficiaries are eligible for monthly cash retirement insurance benefits (also called old-age insurance benefits) when they are age 62 or older, fully insured and have filed an application for those benefits.

Beginning with the year 2000 [workers and spouses born 1938 or later, widow(er)s born 1940 or later], the retirement age increases gradually from age 65 until it reaches age 67 in the year 2022.

If the worker waits until his full retirement age, he will receive the full retirement insurance benefit rate. If a worker age 62 or older chooses to receive retirement benefits for one or more months prior to his retirement age:

1. The benefit rate ordinarily received at retirement age is reduced by a certain percentage for each month the worker is under retirement age when the benefit began, and
2. A reduced benefit rate will continue to be paid after the worker reaches retirement age.

The reduction is made by first determining the full benefit. This benefit rate is then reduced by a specified percentage for each month entitled before FRA. The reduced rate is payable as of the first month of entitlement to benefits. For retirement and spouse’s benefits, an individual must be at least age 62 throughout the month before entitlement to reduced benefits begins.

These reduced benefits continue at a reduced rate even after FRA. The reduced disability insurance benefit is converted at FRA to a reduced retirement insurance benefit.
The reduced benefit rate may be recomputed to include additional earnings. An increase in the benefits, either resulting from additional earnings or from a cost-of-living increase, is reduced in proportion to the reduction in effect in the first month the benefits were elected. A benefit rate may also be increased to give credit for certain months before FRA in which the reduced benefit was not paid.

An additional reduction applies to primary insurance benefits and spouse’s benefits based on the additional reduction period. The modification for widow(er)'s benefits is slightly different. The reduction amount at age 60 remains at 28.5% of the full benefit even as retirement age increases.

**Delaying Retirement**

The delayed retirement credit increases the benefit amount if the worker did not receive benefits for months after reaching FRA. Delayed retirement credit increases apply for benefits beginning January of the year following the year FRA was reached. However, it does not apply to the special minimum primary insurance amount (PIA).

Each month in which a worker is at least FRA, but not yet age 70 (age 72 if they turned age 70 before 1984), is an increment month. An increment month is also any month he is eligible but did not receive a benefit.

The delayed retirement credit is based on increment months. They may increase the benefits by varying amounts, depending on when the individual reaches FRA.

**When Benefits Are Not Payable**

Retirement benefits may not be payable or may be payable only in part if the worker:

1. Is under FRA and earns more than the exempt amount.
2. Is under FRA and works outside the U.S. for more than 45 hours in a month.
3. Is in the U.S. and is neither a citizen nor an alien lawfully present.
4. Has been deported or removed from the U.S.
5. Is an alien who is outside the U.S. for more than six consecutive calendar months and does not meet an exception to the alien nonpayment provisions.
6. Is living in a U.S. Treasury-restricted country where it is not permitted to mail U.S. government payments.
7. Is living in an SSA-restricted country and does not meet an exception.
8. Has waived the right to benefits because he is a member of a recognized religious group that is opposed to insurance. In this situation, he must have been granted exemption from paying the self-employment tax.
9. Is confined within the U.S. in a jail, prison or other penal institution or correctional facility because he has been convicted of a felony.
Benefits End with Death

The benefits end with the worker’s death. No retirement insurance benefit is paid for the month of death. However, survivor benefits may be payable to the worker’s survivors beginning with the month of their death, unless:

1. The worker or the survivor waived the right to benefits because of religious conviction, or
2. The worker or the survivor has been convicted of certain crimes and sentenced accordingly.

Filing an Application

An application must be filed to:

1. Become entitled to benefits, including Medicare;
2. Establish a period of disability under the retirement, survivors and disability insurance programs; or

Applicants should fill out the application on a form issued by the SSA and file the completed and signed application form at [www.socialsecurity.gov](http://www.socialsecurity.gov), a Social Security office or with a person authorized to receive applications. An interpreter to communicate with the SSA will be provided upon request, free of charge.

Timing of the Application

An application for monthly retirement benefits may be filed up to four months before becoming entitled to benefits. An application for disability insurance benefits may be filed before the first month of becoming entitled to benefits. An application for monthly survivor benefits should be filed immediately when meeting all eligibility requirements for benefits on the deceased individual’s record.

If applying for the establishment of a period of disability, an application may be filed before the first day this period begins. An application becomes effective some time before the SSA makes a final decision on the application.

Near retirement age. A worker may contact the Social Security office up to four months before turning 62. The SSA will give the information needed to decide whether or not to file an application for reduced retirement benefits at that time.

If an application is not filed for reduced retirement benefits at age 62, a worker should contact the SSA again:

1. Up to four months before planning to retire;
2. As soon as he knows that he will neither earn more than the monthly exempt amount in wages nor render substantial services in self-employment in one or more months of the year, regardless of expected total annual earnings; or
3. Up to four months before reaching FRA, even if he is still working.
Retroactive Effective Date

An individual may be entitled to monthly benefits retroactively for months before the month they filed an application for benefits. For example, FRA claims and survivor claims may be paid retroactively for up to six months. In certain cases, benefits involving disability for up to 12 months may be paid retroactively. (This is not true of the special age 72 payments, black lung benefits, medical insurance or SSI.)

Determining retroactive date. Individuals are entitled to benefits beginning the first month in the retroactive period that they meet all requirements (except for the filing of an application) for entitlement. For example, suppose an individual reaches full retirement age in March 2010 and is fully insured. He does not file an application for retirement insurance benefits until March 2011. In this case, he may be entitled retroactively beginning with the month of September 2010.

Retroactive Payments

- Before full retirement age (FRA). Retroactive benefits for months prior to attainment of FRA are not payable to a retired worker, spouse or widow(er) if this results in a permanent reduction of the monthly benefit amount. This limitation does not apply to a surviving spouse or surviving divorced spouse under a disability and under age 61 in the month of filing. He may possibly be entitled to benefits as a disabled widow(er) in the retroactive period.

- No longer eligible for benefits. Even if an application is filed and the applicant is no longer eligible for monthly benefits, he may be paid benefits for the period beginning six months (or 12 months in certain cases involving disability) before the month he filed the application if he meets all eligibility factors in the retroactive period. Payment ends with the month before the month he is no longer eligible.

Death before filing application. If an individual requests benefits in a written statement but dies before filing the valid application, benefits may be payable for the months in the period before death. Benefits for the months before the claimant’s death may also be paid to a survivor whose right to benefits depended upon the claimant’s entitlement to benefits.

Restricted retroactivity. An applicant may restrict any retroactive right to benefits. A request can be made in writing at any time before the SSA makes a decision on an application.

The SSA does not use waived months in computing the reduction factor. This may result in a higher benefit amount for later months. An applicant may want to give up benefits for certain months in order to receive somewhat higher benefits later on.

In some cases, an applicant may be eligible for a reduced spouse’s benefit or a reduced divorced spouse’s benefit in the same month they become entitled to retirement insurance benefits (RIB) on their own record. In this instance, the applicant is deemed to have filed for the reduced spouse’s benefit. U.S. law does not permit an applicant to exclude these benefits from the scope of the RIB application.

The opposite of the above is also true. An applicant may not exclude a reduced RIB from the scope of his application for reduced spouse’s benefits if he is eligible for the RIB in the initial month of entitlement to reduced spouse’s benefits.
In certain cases, a decision to restrict retroactivity may be changed. For example, if it is discovered that earnings in the year were more or less than expected, the month of entitlement can be changed to any month within the retroactive period of the original application. However, any other beneficiary who would lose some or all of those benefits because of such a change must agree to it in writing. Additionally, any benefits that were paid based on entitlement cancelled by the change must be repaid.

**Earnings Test**

Social Security benefits are meant to partly replace earnings an individual (or his/her family) loses because of retirement, disability or death. Therefore, the amount of Social Security benefits received each year depends on whether the individual is fully or partially retired.

The SSA uses the earnings test, also referred to as the retirement test, to:

1. Measure the extent of the retirement;
2. Determine the amount, if any, to be deducted from monthly benefits; and
3. Measure the work activity of other individuals entitled to benefits on the record and the amount of benefits payable to them.

The earnings test does not apply if an applicant is:

1. FRA,
2. Entitled to benefits because of a disability, or
3. Living outside the U.S. and his work is not covered by Social Security. In this case, the foreign work test applies.

**Excess Earnings**

Excess earnings are earnings that exceed the annual exempt amount.

**Effect on benefit amount.** If an applicant is younger than FRA, his excess earnings are subject to a $1 deduction from benefits for each $2 he earns. In the year he reaches FRA, he is subject to a different annual exempt amount, and his excess earnings are subject to a $1 deduction from benefits for each $3 he earns.

**Annual exempt amounts.** There is an annual exempt amount prior to year of FRA attainment. In the year an applicant reaches FRA, he is subject to a different annual exempt amount. The exempt amounts also vary from year to year according to increases in the nationwide earnings level. The exempt amounts are computed each year according to the formula provided in the Social Security Act. This formula takes into account increases in national earnings levels.

The annual exempt earnings amount for 2011 is $37,680 for the year of full retirement age, and $14,160 prior to the year of full retirement age.

**Applying the exempt amount.** The higher exempt amount applies if an applicant reaches FRA on or before the last day of the taxable year involved. The lower exempt amount applies if the applicant does not reach FRA on or before the last day of the taxable year.
Impact of Excess Earnings

When there are excess earnings, these earnings are charged against and deducted from the benefits. The deductions begin with the first chargeable month of the taxable year and continue each month until all excess earnings have been charged.

**Family benefits.** If retirement insurance benefits are received, the excess earnings are charged against the total monthly family benefit. This reduces the total family benefit. The family benefit includes all monthly benefits (other than disability insurance benefits) payable to the individual and anyone else (for example, spouse or child) entitled to benefits on the earnings record. It also includes benefits payable to a spouse on any earnings record as a disabled child, mother or father.

Excess earnings do not cause deductions from the benefits of an entitled divorced spouse who has been divorced from the applicant for at least two years in a row.

**Example:** Mr. Bond is entitled to a retirement insurance benefit of $378. His wife and child are each entitled to an auxiliary benefit of $160. Mr. Bond worked and had excess earnings of $4,188 in the year of full retirement for a loss of benefits of $2,094. These earnings are charged against the total monthly family benefit of $698 [$378 plus (2 × $160)]. Therefore, no benefits are payable to the family for January through March (3 × $698 = $2,094).

**Survivor or other person.** If a survivor or other individual entitled to benefits on the Social Security record has excess earnings, only his monthly benefit amount is charged and deducted.

**Example:** Same facts as the example above, except it was the wife who worked. Her excess earnings were $1,600 in the year of full retirement for a loss of benefits of $800, which are charged only against her own monthly benefit of $160. She therefore receives no payments for January through May (5 × $160 = $800).

If the applicant and an individual entitled to benefits on their earnings record (auxiliary) both have excess earnings:

1. First, excess earnings of the applicant are charged against the total monthly family benefit; and
2. Next, the auxiliary’s excess earnings are charged against his own benefits. However, they are only charged to the extent that those benefits have not already been charged with excess earnings of the applicant.
Example: Mrs. Malcolm is entitled to a retirement insurance benefit of $346, and her husband is entitled to a spouse’s insurance benefit of $173. Mrs. Malcolm had excess earnings of $4,152 for a loss of $2,076 in benefits. Her husband had excess earnings of $1,730 for a loss of $865.

Mrs. Malcolm’s earnings are charged against the total monthly family benefit of $519 ($346 + $173), so neither Mrs. Malcolm nor her husband receives payments for January through April (4 × $519 = $2,076). The husband’s excess earnings are charged only against his own benefit of $173. Since his benefits for January through April were charged with the worker’s excess earnings, the charging of his own earnings cannot begin until May; therefore, he receives no benefits for May through September (5 × $173 = $865).

No Charge for Excess Earnings

Excess earnings are not charged against benefits for any month in which the applicant:

1. Was not entitled to benefits.
2. Was FRA or over in any part of the month.
3. Met the following conditions:
   a. He was in a grace year,
   b. He did not work for wages higher than the monthly exempt amount, and
   c. He did not perform substantial services in self-employment.
4. Was entitled to a disability insurance or a childhood disability benefit.
5. Was entitled to a widow(er)’s or surviving divorced spouse’s insurance benefit because of a disability.
6. Was entitled to a wife’s, husband’s, mother’s or father’s insurance benefit but were subject to a deduction because they did not have the spouse’s (or former spouse’s) child in care.
7. Was subject to a deduction because of their own non-covered work for pay outside the U.S.
8. Was subject to a deduction because the worker on whose earnings record they are entitled to benefits performed noncovered work for pay outside the U.S.
9. Was subject to a deduction because the worker on whose earnings record they are entitled to benefits refused to accept vocational rehabilitation services.
10. Did not receive payment because periodic worker’s compensation benefits prevented such payment.
11. Was entitled to student benefits based on full-time attendance at a postsecondary school and did not receive benefits for the summer months.

Excess earnings of a retirement insurance beneficiary are not charged against the benefits of an individual entitled to benefits on the worker’s earnings record (the auxiliary) for any month in which the auxiliary is subject to a deduction under 4, 5 or 6 above.
Partial Benefits

An individual may receive a partial monthly benefit when their excess earnings remaining uncharged for the year are less than the amount of their total benefit for the next month, subject to charging.

The partial payment is paid only at the close of the taxable year when they file the annual report of earnings unless otherwise requested. When the partial monthly benefit is not a multiple of $1, the monthly benefit amount is rounded to the next lower multiple of $1. (See the example below.)

Only one beneficiary. If there is only one beneficiary involved, the partial benefit paid is the difference between the monthly benefit amount and the excess earnings charged to the month.

Example: Ms. Ridgely has a monthly benefit amount of $288.20. She has excess earnings that result in a loss of benefits of $700 that are charged against her benefits beginning with January. This results in the loss of her entire benefit for January and February, plus $123.60 of the March payment [(2 × $288.20) plus $123.60 = $700]. She receives a partial monthly benefit of $164.00 for March ($288.20 – $123.60 = $164.60 rounded to the next lower multiple of $1).

Multiple beneficiaries. When excess earnings are charged against the family benefits of a retirement insurance beneficiary and one or more persons are entitled to benefits on the worker’s earnings record, the partial benefit is allocated to each person entitled to benefits. The partial benefit is allocated in the proportion to the original entitlement rate of the beneficiary on the worker’s earnings record. However, a beneficiary’s prorated share of the partial benefit may not be more than the benefit amount that would have been paid if there were no work deductions.

The original entitlement rate means the respective benefit rate as figured without:
1. Adjustment for the family maximum,
2. Adjustment for entitlement before FRA, and
3. Any reduction because of an auxiliary’s entitlement to a retirement or disability insurance benefit.

Example: Mr. Star, his wife and their two children are entitled to benefits. After charging Mr. Star’s excess earnings against the total monthly family benefit, a partial benefit of $100 is payable to the family. The chart below shows the amount each family member will receive.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Original Benefit Amounts</th>
<th>Ratio of Original Benefit</th>
<th>Actual Benefits Under Family Maximum</th>
<th>Prorated Share of Partial Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Star</td>
<td>$194.00</td>
<td>(2/5)</td>
<td>$194.00</td>
<td>$40 (2/5 × 100)</td>
</tr>
<tr>
<td>Wife</td>
<td>97.00</td>
<td>(1/5)</td>
<td>32.40</td>
<td>20 (1/5 × 100)</td>
</tr>
<tr>
<td>Child</td>
<td>97.00</td>
<td>(1/5)</td>
<td>32.40</td>
<td>20 (1/5 × 100)</td>
</tr>
<tr>
<td>Child</td>
<td>97.00</td>
<td>(1/5)</td>
<td>32.40</td>
<td>20 (1/5 × 100)</td>
</tr>
<tr>
<td>Total</td>
<td>$485.00</td>
<td>–</td>
<td>$291.20</td>
<td>$100</td>
</tr>
</tbody>
</table>
Computing Total Earnings

Under the earnings test, the earnings for a taxable year consist of:

1. The sum of the wages for services performed in the year, plus
2. All net earnings from self-employment for the year, minus
3. Any net loss from self-employment for the year.

It does not matter who the final recipient of the income is when applying the earnings test. If the income is actual wages for services performed or net earnings from self-employment, they must be included as income when applying the earnings test. It also does not matter what the earnings are called (for example, dividends, rent, refund of loans, etc.). The SSA looks closely at arrangements of this nature.

Example: Mr. Smith continues to perform services for a family, close corporation, trade or business owned by him. Mr. Smith later transfers ownership to a relative. If Mr. Smith is receiving income, directly or indirectly (that is, wages for the services or net earnings from self-employment) he must include that income in applying the earnings test.

Benefits only part year. The SSA counts the earnings for the entire taxable year in applying the earnings test. This is true even if the individual is not entitled to benefits for the entire year.

Year FRA reached. The SSA does not count earnings if they were earned in or after the month reaching FRA.

Excluded earnings. The following types of earnings income (or losses) do not count as earnings from employment or self-employment under the earnings test:

1. Any income from employment or self-employment earned in or after the month the individual turns FRA.
2. Any income from self-employment received in a taxable year after the year the individual becomes entitled to benefits. Such income must not be attributable to services performed after the first month of entitlement to benefits.

   This income is excluded from gross income only for purposes of the earnings test.
3. Damages, attorneys’ fees, interest or penalties paid under court judgment or by compromise settlement with the employer based on a wage claim.

   Any back pay recovered in a wage claim counts for the earnings test.
4. Payments to secure release of an unexpired contract of employment.
5. Certain payments made under a plan or system established for making payments because of the employee’s sickness or accident disability, medical or hospitalization expenses or death.
6. Payments from certain trust funds that are exempt from income tax.
7. Payments from certain annuity plans that are exempt from income tax.
8. Pensions and retirement pay.
9. Sick pay if paid more than six months after the month the employee last worked.

10. Payments-in-kind for domestic services in the employer’s private home for:
    a. Agricultural labor,
    b. Work not in the course of the employer’s trade or business, or
    c. The value of meals and lodging furnished under certain conditions.

11.Rentals from real estate that cannot be counted in earnings from self-employment (for example, the beneficiary did not materially participate in production work on the farm, the beneficiary was not a real estate dealer, etc.).

12. Interest and dividends from stocks and bonds (unless they are received by a dealer in securities in the course of business).

13. Gain or loss from the sale of capital assets, or sale, exchange or conversion of other property that is not stock in trade nor considered inventory.

14. Net operating loss carry-over resulting from self-employment activities.

15. Loans received by employees, unless the employees repay the loans by their work.

16. Worker’s compensation and unemployment compensation benefits.

17. Veteran’s training pay.

18. Pay for jury duty.

19. Prize winnings from contests, unless the person enters contests as a trade or business.

20. Tips paid to an employee that are less than $20 per month or are not paid in cash.

21. Payments by an employer that are reimbursement specifically for travel expenses of the employee and are so identified by the employer at the time of payment.

22. Payments to an employee as reimbursement or allowance for moving expenses, if they are not counted as wages for Social Security purposes.

23. Royalties received in or after the year a person reaches FRA. The royalties must flow from property created by the individual’s own personal efforts that he copyrighted or patented before the taxable year in which he received FRA.

   These royalties are excluded from gross income from self-employment only for purposes of the earnings test.

24. Retirement payments received by a retired partner from a partnership, provided certain conditions are met.

25. Certain payments or a series of payments paid by an employer to an employee or an employee’s dependents on or after the employment relationship has ended due to death, retirement for disability or retirement for age.

26. Payments from IRAs and Keogh plans.
SELF-STUDY QUIZ

Determine the best answer for each question below. Then check your answers with the correct answers in the following section.

5. In which one of the following scenarios would the worker’s benefit amount increase?
   a. Annabelle chose to receive retirement benefits three months before her retirement age.
   b. Abby chose to receive retirement benefits at her full retirement age.
   c. Arthur reached full retirement age nine months ago but did not choose to receive benefits.

6. Wes files an application for retirement insurance benefits in November 2011. He was fully insured and reached full retirement age in August 2011. Assuming he is eligible, his retroactive retirement insurance benefits would begin with which month?
   b. May 2011.

7. Which of the following choices is correct concerning retroactive retirement benefits?
   a. Emma applied for retirement benefits four months ago. She was eligible for benefits at that time; however, she is not currently eligible. Emma may be able to receive retroactive payments.
   b. Bart, a retired worker, applies for retroactive benefits for the time period before he reached full retirement age. He may receive retroactive benefits even though this will cause a permanent reduction of the monthly benefit amount.
   c. Marge previously requested benefits in a written statement; however, she passed away before filing a valid application for retirement benefits. Benefits will not be paid since a valid application was not filed.
   d. Thomas previously requested a restriction of retroactive rights to benefits. He subsequently discovered that earnings in a year were different than expected. His decision to restrict retroactivity may not be changed.

8. For which of the following would the earnings test apply?
   a. Parker chooses to receive early retirement benefits while she works part-time in retail.
   b. Donald resides in a foreign country. His work is not covered by Social Security.
   c. Earl, 56 years of age, receives benefits due to a disability.
9. Dr. Evans is receiving Social Security benefits and turns 66 on December 31, 2011. He continues to work part-time and had earnings of $15,000 in 2010, and $40,000 in 2011. How much of his excess earnings were subject to benefit deduction in 2010?

a. $0.
b. $2,320.
c. $840.
d. $25,840.

10. Using the same information in the prior question, by what amount are Dr. Evans’ benefits reduced in 2010?

a. $420.
b. $280.

d. $25,840.

11. Mr. Adams, his wife, and their two children receive retirement insurance benefits. The total monthly family benefit will be reduced to $300 due to excess earnings. How much will Mr. Adams’ portion be? (Assume an adjustment for the family maximum is unnecessary.)

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Original Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Adams</td>
<td>$300</td>
</tr>
<tr>
<td>Wife</td>
<td>$100</td>
</tr>
<tr>
<td>Child</td>
<td>$100</td>
</tr>
<tr>
<td>Child</td>
<td>$100</td>
</tr>
</tbody>
</table>

a. $50.
b. $100.
c. $150.
d. $300.

12. Mrs. Tardella reached her FRA in June of the current year. She earned $3,500 per month as a first-grade teacher, $12,000 from renting out her vacation home in Colorado during ski season, and a stock dividend of $200 for the first quarter. What are her total earnings for the year under the earnings test?

a. $17,500.
b. $21,000.
c. $29,700.
d. $42,000.
SELF-STUDY ANSWERS

This section provides the correct answers to the self-study quiz. If you answered a question incorrectly, reread the appropriate material in this lesson. (References are in parentheses.)

5. In which one of the following scenarios would the worker’s benefit amount increase? (Pages 21)

   a. Annabelle chose to receive retirement benefits three months before her retirement age. [This answer is incorrect. If a worker age 62 or older chooses to receive retirement benefits for one or more months prior to her retirement age, a reduced benefit rate will be paid and will continue even after the worker reaches retirement age.]

   b. Abby chose to receive retirement benefits at her full retirement age. [This answer is incorrect. A worker who waits until her normal retirement age will receive the full retirement insurance benefit rate. The benefit amount would not increase or decrease.]  

   c. Arthur reached full retirement age nine months ago but did not choose to receive benefits. [This answer is correct. The delayed retirement credit increases the benefit amount. Individuals who choose to defer or delay their retirement beyond normal retirement age receive an additional credit for each month they do not receive benefits after attaining full retirement age but before age 70.]

6. Wes files an application for retirement insurance benefits in November 2011. He was fully insured and reached full retirement age in August 2011. Assuming he is eligible, his retroactive retirement insurance benefits would begin with which month? (Page 23)

   a. August 2011. [This answer is correct. FRA claims and survivor claims may be paid retroactively for up to six months.]

   b. May 2011. [This answer is incorrect. The retroactive period doesn’t begin until the individual reaches full retirement age.]

7. Which of the following choices is correct concerning retroactive retirement benefits? (Page 23)

   a. Emma applied for retirement benefits four months ago. She was eligible for benefits at that time; however, she is not currently eligible. Emma may be able to receive retroactive payments. [This answer is correct. Even if an application is filed and the applicant is no longer eligible for monthly benefits, an individual may be paid benefits for the period beginning six months (or 12 months in certain cases involving disability) before the month she filed the application if she meets all eligibility factors in the retroactive period.]

   b. Bart, a retired worker, applies for retroactive benefits for the time period before he reached full retirement age. He may receive retroactive benefits even though this will cause a permanent reduction of the monthly benefit amount. [This answer is incorrect. Retroactive benefits for months prior to attainment of FRA are not payable to a retired worker, spouse or widow(er) if this results in a permanent reduction of the monthly benefit amount per the SSA.]
c. Marge previously requested benefits in a written statement; however, she passed away before filing a valid application for retirement benefits. Benefits will not be paid since a valid application was not filed. [This answer is incorrect. Per the SSA, if an individual requests benefits in a written statement but dies before filing the valid application, benefits may be payable for the months in the period before death.]

d. Thomas previously requested a restriction of retroactive rights to benefits. He subsequently discovered that earnings in a year were different than expected. His decision to restrict retroactivity may not be changed. [This answer is incorrect. In certain cases, a decision to restrict retroactivity may be changed if it is discovered that earnings in the year were more or less than expected. The month of entitlement can be changed to any month within the retroactive period or the original application.]

8. For which of the following would the earnings test apply? (Page 24)

a. Parker chooses to receive early retirement benefits while she works part-time in retail. [This answer is correct. The SSA uses the earnings test to measure the extent of retirement. The test applies to all applicants unless one of the three exceptions exists.]

b. Donald resides in a foreign country. His work is not covered by Social Security. [This answer is incorrect. Donald is not subject to the earnings test because he is living outside the U.S. and his work is not covered by Social Security. The foreign work test would apply.]

c. Earl, 56 years of age, receives benefits due to a disability. [This answer is incorrect. Per the SSA, the earnings test does not apply when an applicant is entitled to benefits because of a disability.]

9. Dr. Evans is receiving Social Security benefits and turns 66 on December 31, 2011. He continues to work part-time and had earnings of $15,000 in 2010, and $40,000 in 2011. How much of his excess earnings were subject to benefit deduction in 2010? (Page 25)

a. $0. [This answer is incorrect. This is the amount of excess earnings that would be exempt if Dr. Evans had $15,000 in excess earnings in the year he reached FRA, $15,000 – $37,680 = $0.]

b. $2,320. [This answer is incorrect. This is the amount of exempt earnings for 2011, the year in which Dr. Evans reaches FRA, $40,000 – $37,680 = $2,320.]

c. $840. [This answer is correct. The annual exempt earnings amount for the year prior to the year of FRA is $14,160; therefore, $840 of Dr. Evans’ excess earnings were subject to benefit reduction in 2010, the year before he reached FRA, $15,000 – $14,160 = $840.]

d. $25,840. [This answer is incorrect. This is the amount of excess earnings that would be exempt if Dr. Evans had $40,000 in excess earnings in the year before he reached FRA, $40,000 – $14,160 = $25,840.]
10. Using the same information in the prior question, by what amount are Dr. Evans’ benefits reduced in 2010? (Page 24)
   a. $420. [This answer is correct. If an applicant is younger than FRA, his excess earnings are subject to a $1 deduction from benefits for each $2 he earns, $840/2 = $420.]
   b. $280. [This answer is incorrect. In the year an applicant reaches FRA, his excess earnings are subject to a $1 reduction from benefits for each $3 he earns, $840/3 = $280.]

11. Mr. Adams, his wife, and their two children receive retirement insurance benefits. The total monthly family benefit will be reduced to $300 due to excess earnings. How much will Mr. Adams’ portion be? (Assume an adjustment for the family maximum is unnecessary.) (Page 27)

<table>
<thead>
<tr>
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</tr>
</thead>
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<td>Child</td>
<td>$100</td>
</tr>
<tr>
<td>Child</td>
<td>$100</td>
</tr>
</tbody>
</table>

   a. $50. [This answer is incorrect. $50 is the benefit for Mrs. Adams and each of the kids. Their entitlement rate is 1/6.]
   b. $100. [This answer is incorrect. $100 is the original benefit amount for Mrs. Adams and each of the kids.]
   c. $150. [This answer is correct. The partial benefit is allocated in the proportion to the original entitlement rate of the beneficiary on the worker’s earnings records. The ratio is ½ for Mr. Adams.]
   d. $300. [This answer is incorrect. When excess earnings are charged against the family benefits of a retirement insurance beneficiary and one or more persons are entitled to benefits on the worker’s earnings record, the partial benefit is allocated to each person entitled to benefits.]

12. Mrs. Tardella reached her FRA in June of the current year. She earned $3,500 per month as a first-grade teacher, $12,000 from renting out her vacation home in Colorado during ski season, and a stock dividend of $200 for the first quarter. What are her total earnings for the year under the earnings test? (Pages 28)

   a. $17,500. [This answer is correct. Since the SSA doesn’t count earnings that were earned in or after the month reaching FRA, only her teaching wages for January–May are included in total earnings, $3,500 × 5 = $17,500.]
   b. $21,000. [This answer is incorrect. In computing total earnings, the SSA doesn’t count earnings in the month of reaching FRA.]
   c. $29,700. [This answer is incorrect. Dividend and rental income are excluded from the computation of total earnings.]
   d. $42,000. [This answer is incorrect. The year an individual reaches FRA, any earnings for the month the FRA was reached or subsequent months are not counted by the SSA.]
EXAMINATION FOR CPE CREDIT

Lesson 2

Determine the best answer for each question below, then log onto our Online Grading System at cl.thomsonreuters.com/ogs to record your answers.

5. Which of the following workers may be eligible for more than partial retirement benefits?
   a. Edward was convicted of a felony and is serving time in a Texas correctional facility.
   b. Bella reached age 62 and earns more than the exempt amount.
   c. Bo reached age 62 but worked in China for 60 hours one month.
   d. Eric is a retired U.S. citizen, age 67, and lives in California.

6. Ted, age 75, died in April. Ted's daughter Teddy is eligible for survivor benefits. How many months of retirement insurance benefits did Ted receive in the current year and how many months of survivor benefits did Teddy receive in the current year?
   d. Ted 4, Teddy 8.

7. When should an application for monthly retirement benefits be filed?
   a. Four months after eligibility.
   b. Immediately upon eligibility.
   c. Before the first month of entitlement.
   d. Up to four months before entitlement.

8. Sadie Jo turns 66 on June 1, 2011. She earns $75,000 in 2011, and $65,000 in 2010. What amount of her excess earnings are subject to benefit deduction in the year she reaches FRA?
   a. $0.
   b. $37,320.
   c. $50,840.
   d. $60,840.
9. Excess earnings are charged against and deducted from which of the following benefits?
   a. The total family benefit when one member has excess earnings.
   b. An entitled divorced spouse’s benefit. The couple has been divorced for three years.
   c. The worker received periodic worker’s compensation benefits.
   d. The retirement benefit when the worker was in a grace year.

10. Mr. Mitchell had excess earnings of $5,300. After charging his excess earnings against the total monthly plan benefit, the monthly benefit payable to the family is $300. Mr. Mitchell originally received $250, his wife Melissa received $125, and their daughter Lucy received $125. How much will Lucy’s payment be after the adjustment?
   a. $250.
   b. $150.
   c. $125.
   d. $75.

11. Melissa quit her full time job at a mobile phone store to open a cat grooming business in 2010. Her net income from grooming cats was $2,600 and she earned $26,000 from the phone store. She also earned dividend income of $260 and rental income of $620. What are her total earnings for the year under the earnings test?
   a. $29,480.
   b. $28,860.
   c. $28,600.
   d. $26,880.

12. Which of the following would be included in computing total earnings under the earnings test?
   a. Tully received $3 per day for her service as a juror.
   b. Barb received a considerable amount of cash tips.
   c. Terrance received $800 per month from a pension plan.
   d. Molly had a long-term capital gain on the sale of stock.
Lesson 3: Retirement Benefits for Families

Learning Objectives

Completion of this lesson will enable you to:

- Identify the basic requirements for spousal benefits, children’s benefits, and the maximum family benefit.

Spousal Benefits

Social Security Definition of Spouse

An individual must meet one of the conditions below at the time application for benefits is made. Under applicable law, he must:

1. Be validly married to the worker;
2. Have marital status with respect to the taking of intestate personal property; or
3. Have an invalid marriage to the worker under applicable law because of an impediment from a prior marriage or its dissolution, or from a procedural defect, provided:
   a. The individual married the worker in good faith, not knowing of any defect at the time of the marriage;
   b. The individual was living with the worker in the same household when benefits were applied for (unless divorced from the worker at the time); and
   c. For benefits payable prior to January 1991, no other individual was entitled to benefits as a spouse of the worker.

Entitlement to Benefits

The spouse of an insured worker is entitled to benefits based on the worker’s Social Security record if the following conditions are met:

1. The worker is entitled to retirement or disability insurance benefits.
2. An application for spousal benefits has been filed.
3. The spouse is not entitled to a retirement or disability insurance benefit based on a primary insurance amount that equals or exceeds half the worker’s primary insurance amount.
4. The spouse is either:
   a. Age 62 or over, or
   b. Caring for a child who is under age 16 or disabled and entitled to benefits on the worker’s Social Security record.
5. The spouse must either:
   a. Have been married to the worker for at least one continuous year before filing an application for benefits.
   b. Be the natural parent of the worker’s biological child.

   This requirement is met if a live child was born, even if the child is no longer living.
c. Be entitled or potentially entitled to spouse’s, widow(er)’s, parent’s or child’s disability benefits based on the record of a fully insured individual under the Social Security Act in the month before the month he married the worker. **Note:** Includes deemed or divorced spouse, deemed widow(er) or surviving divorced spouse. Potentially entitled means all requirements for entitlement other than filing of an application have been met, and for a spouse’s, widow(er)’s or parent’s benefits, attaining the required age.

d. Be entitled or potentially entitled to a widow(er)’s, parent’s or child’s (age 18 or over) annuity under the Railroad Retirement Act in the month before the month he married the worker.

**Divorced spousal benefits.** An individual is entitled to a divorced spouse’s insurance benefits on the worker’s Social Security record if:

1. The worker is entitled to retirement or disability insurance benefits;
2. He filed an application for divorced spouse’s benefits;
3. He is not entitled to a retirement or disability insurance benefit based on a primary insurance amount that equals or exceeds one-half the worker’s primary insurance amount;
4. He is age 62 or over;
5. He is not married; and
6. He was married to the worker for at least 10 years before the date the divorce became final.

The divorced spouse is not entitled to benefits before age 62, even if he has an entitled child in care. The divorced spouse of a worker who is not entitled to his own retirement or disability insurance benefits, but has reached age 62 and is fully insured, can become independently entitled to benefits on the worker’s earnings record. To do so, however, the divorced spouse must meet the requirements in items 2–6 above and have been divorced from the worker for not less than two continuous years.

**Amount of Spouse’s Benefit**

The spouse’s insurance benefit is one-half of the worker’s primary insurance amount. However, the benefit paid may be less than half of the worker’s primary insurance amount if:

1. The family maximum applies;
2. The spouse is entitled to a retirement, disability or widow(er)’s insurance benefit that is smaller than the spouse’s benefit rate so that only the difference between the retirement, disability or widow(er)’s benefit and the spouse’s benefit rate is paid;
3. The spouse qualified for a reduced spouse’s benefit before normal retirement age; or
4. The spouse receives a government pension and is not covered by Social Security. The benefit can be reduced by government pension offset.

Regardless of age, if the spouse of a retired or disabled worker is caring for a child who is either under age 16 or disabled, he will receive the full spouse benefit (one-half of the worker’s primary insurance).

**Reduced amount prior to full retirement age.** If a spouse chooses to receive, and is paid, a reduced spouse’s benefit before full retirement age, he is not entitled to the full spouse’s
benefit rate upon reaching full retirement age. A reduced benefit rate is payable for as long as he remains entitled to spouse’s benefits.

**Divorced spouse’s benefits.** A divorced spouse’s benefit is not reduced under the family maximum.

If the spouse does not have the worker’s entitled child in his care in the first month of his entitlement and has not reached full retirement age, the benefit is reduced under item 3 above. If the spouse has such a child in care in that month, the benefit is not reduced. It remains unreduced even for later months before full retirement age in which no child is in his care.

**When Spousal Benefits End**

The spouse’s or divorced spouse’s insurance benefits end when any of the following conditions are met:

1. Spouse dies.
2. Worker dies [spouse may be entitled to widow(er)’s, mother’s or father’s benefits].
3. Worker’s entitlement to disability insurance benefits ends and he is not entitled to retirement insurance benefits unless a divorced spouse meets requirements for an independently entitled divorced spouse.
4. The spouse is under age 62 and there is no longer a child of the worker under age 16 or disabled entitled to child’s insurance benefits.
5. The spouse becomes entitled to retirement or disability insurance benefits and the primary insurance amount is at least one-half of worker’s primary insurance amount.
6. The spouse and worker are divorced, unless:
   a. The spouse already turned age 62 when divorce became final, and
   b. The spouse and worker had been married at least 10 years before date divorce became final.
7. Spouse qualifies for benefits only under conditions explained above and later learns marriage is invalid.
8. Divorced spouse marries someone of the opposite gender other than worker. **Note:** Divorced spouse’s benefit is not ended by marrying the individual entitled to the divorced spouse’s, widow(er)’s, mother’s, father’s or parent’s monthly benefits, or to an individual age 18 or over entitled to childhood disability benefits.
9. For an independently entitled divorced spouse, the worker is no longer fully insured or he marries the worker.

**Child’s Benefits**

**Entitlement to Benefits**

A child is entitled to child’s insurance benefits on the Social Security record of a parent if the following conditions are met:

1. An application for child’s insurance benefits is filed.
2. Child is (or was) dependent upon the parent.
3. Child is not married.

4. Child is:
   a. Under age 18,
   b. Age 18–19 and a full-time elementary or secondary school student, or
   c. Age 18 or older and under a disability (must have begun before age 22), and

5. Parent is:
   a. Entitled to disability insurance benefits,
   b. Entitled to retirement insurance benefits, or
   c. Deceased and either fully or currently insured at time of death.

Definition of Child

The term child includes the worker’s:

1. Natural (that is, biological) legitimate child, or any other child with the right under applicable state law to inherit intestate personal property from the worker as a child.

   Applicable state law is the law of the state where worker was domiciled at the time of death. If the worker was not domiciled in any state, the law of the District of Columbia applies.

2. Stepchild, under certain circumstances.

3. Legally adopted child.

4. Child of invalid ceremonial marriage entered into under conditions explained under “Child qualifying in an invalid marriage” later in this section.

5. Natural child, if the worker:
   a. Has acknowledged in writing child is son or daughter,
   b. Has been decreed by a court to be the parent of the child,
   c. Has been ordered by a court to contribute to support of the child because the child is the worker’s son or daughter,
   d. Has been shown to be child’s parent by other acceptable evidence and was living with child or contributing to child’s support when child’s application is filed (in life cases) or when worker died (in survivor cases).

   A court action referred to in 5b and c above must be made before the death of the worker.


Grandchildren. A dependent grandchild or step-grandchild of worker or spouse may qualify for benefits as a child if:

1. The grandchild’s natural or adoptive parents are deceased or disabled:
   a. At time worker became entitled to retirement or disability insurance benefits or died, or
   b. At beginning of worker’s period of disability that continued until worker became entitled to disability or retirement insurance benefits or died.
2. The grandchild was legally adopted by worker’s surviving spouse in an adoption decreed by a court of competent jurisdiction within the U.S. Grandchild’s natural or adopting parent or stepparent must not have been living in same household nor making regular contributions to child’s support at the time the insured worker died.

In addition to meeting the requirement in items 1 or 2, the grandchild or step-grandchild must be dependent or insured as described under “Child dependent upon a grandparent” later in this section.

**Legally adopted children.** A legally adopted child of the worker is a child who was legally adopted under the adoption laws of the state or foreign country where the adoption took place.

A child who is legally adopted by a worker’s surviving spouse after the worker’s death is considered the worker’s legally adopted child as of the date of death if:

1. The child was either living with or receiving one-half support from the worker at the time of death, and
2. One of the following is met:
   a. The worker started proceedings to adopt the child before death.
   b. The child was adopted by the worker’s surviving spouse within two years of the worker’s death.

The effective date of an adoption decree is important in deciding when an adopted child becomes entitled to benefits. The effective date of an adoption is determined by the law of the state where the adoption took place.

In some cases, a worker may not complete a contemplated adoption. Most states give a child inheritance rights in the worker’s intestate personal property if certain conditions are met. If so, the child may qualify for benefits as an equitably adopted child.

Generally, the following conditions must be met to qualify as an equitably adopted child:

1. An express or, in some states, implied contract for the worker to adopt the child;
2. A legal consideration for the worker’s promise to adopt;
3. In some states, a promise to give the child inheritance rights in the worker’s personal property;
4. Surrender of the child to the worker;
5. Performance by the child under the contract; and
6. Sufficient lapse of time whereby the child could have been legally adopted under applicable state law.

All pertinent documents, together with complete and detailed statements of the parties and other individuals having knowledge of the facts, setting forth full information about the factors listed above must be submitted. Each case must be handled on an individual basis.

An equitably adopted child must have been living with or receiving contributions from the worker at the applicable time.
**Stepchildren.** In general, a stepchild-stepparent relationship arises when an individual:

1. Marries a child’s natural parent (generally, after the child’s birth), or
2. Marries a child’s adopting parent after the adoption.

If the parent dies, a stepchild’s entitlement to benefits does not end.

Once a stepchild is entitled, a divorce ending the parent’s marriage (including an invalid ceremonial marriage) to the stepparent ends the child’s benefits in or after July 1996.

To qualify for benefits, the step relationship has to be in existence as follows: If the parent is living, the stepchild must have been a stepchild of the insured worker for at least one year before filing an application. To qualify for survivors benefits, a stepchild must have been the stepchild of the insured worker for at least nine months before the day that the worker died, unless the worker and the child’s natural or adopting parent were previously married, divorced and then remarried at the time of the worker’s death and the nine-month duration-of-relationship requirement was met at the time of the divorce.

If the death of the worker was accidental or occurred in the line of duty while a member of a uniformed service serving on active duty, the nine-month requirement may be waived, unless the worker could not have been expected to live for nine months at the time of marriage.

**Dependent of Worker**

A child must be dependent upon the worker to qualify for benefits on the worker’s Social Security record. The factors that determine whether a child is dependent upon a worker vary, depending upon whether the worker is the natural parent, the legally adopting parent, the stepparent or the grandparent. The various dependency tests are set out below.

**Child presumed to be dependent.** A child is presumed dependent upon the worker if:

1. The child has not been legally adopted by someone other than the worker during the worker’s lifetime, and
2. The child is one of the following:
   a. The legitimate child of the worker.
   b. A child born out of wedlock who would have the right under applicable state law to inherit intestate property from the worker as a child.
   c. The child of a void or voidable marriage.
   d. The child of an invalid ceremonial marriage.
   e. A deemed child under Section 216(h)(3) of the Social Security Act, under certain circumstances.
   f. The legally adopted child of the worker adopted before the worker’s entitlement to benefits.

A natural or legally adopted child who was legally adopted by someone other than the worker during the worker’s lifetime must have been living with or receiving contributions from the worker at the applicable time.
**Child dependent upon a stepparent.** A child is dependent upon a stepparent if the stepparent was contributing at least half the child’s support at the applicable time. A stepchild entitled before July 1996 could meet an alternate requirement that he must have been living with the worker.

**Child dependent upon a grandparent.** To be dependent on the worker, a grandchild (or step-grandchild) must have:

1. Begun living with the worker before attaining the age of 18, and
2. Lived with the worker in the U.S. and received at least one-half support from the worker:
   a. For the year before the month the worker became entitled to retirement or disability insurance benefits or died; or
   b. If the worker had a period of disability that lasted until he became entitled to benefits or died, for the year immediately before the month in which the period of disability began.

If a grandchild was born during the one-year period, the worker must have lived with and provided at least one-half of the grandchild’s support for a substantial portion (perhaps all) of the grandchild’s life up to the month the grandparent became entitled to retirement or disability benefits or died.

**Amount of Child’s Benefits**

A child’s monthly benefit rate is:

1. One-half the insured parent’s primary insurance amount if the parent is entitled to disability or retirement insurance benefits, or
2. Three-fourths of the parent’s primary insurance amount if the parent is dead.

**Reduced benefit.** The benefit paid to a child may be less if:

1. The family maximum applies and the benefit rate must be reduced.
2. A disabled child is entitled to disability or retirement insurance benefits on his own Social Security record. In this case, only the excess is paid as the child’s insurance benefit.

**Termination of Child’s Benefits**

A child’s insurance benefit payments end when:

1. The child dies.
2. The child reaches age 18 and is neither disabled nor a full-time student. (For a situation where a student may continue to be entitled to child’s benefits, even though he has reached age 19.)
3. The child marries. If the child is a childhood disability beneficiary and the marriage is to another Social Security beneficiary, it will not ordinarily terminate benefits.
4. The child’s parent is no longer entitled to disability insurance benefits, unless the entitlement ended because the insured parent became entitled to retirement insurance benefits or died.

The beneficiary is not entitled to child’s insurance benefits for the month in which any of the above events occur. However, in the case of a disabled child, the child’s benefits end with the second month following the month in which he is no longer disabled.

**Maximum Family Benefits**

There is a maximum family benefit payable on a Social Security record. Generally, no more than the established maximum can be paid to a family, regardless of the number of beneficiaries entitled on that Social Security record. The family maximum is determined by the method of computing the primary insurance amount (PIA) and the kind of benefits payable to the worker.

**Adjusting Individual Benefit Rates**

An adjustment is required whenever the total monthly benefits of all beneficiaries entitled on one Social Security earnings record exceed the family maximum that can be paid on that record for the month. All benefit rates (except retirement or disability insurance benefits and benefits payable to a divorced spouse or surviving divorced spouse) must be reduced to bring the total monthly benefits payable within the family maximum.

**Beneficiary’s benefit rate is a percentage of the insured individual’s PIA.** Even if a beneficiary’s benefit rate is originally set by law as a percentage of the insured individual’s PIA, the actual benefit paid to the beneficiary may be less if the family maximum is exceeded.

**Exceeding the family maximum.** The family maximum may be exceeded only by the effect of saving clauses and certain entitlement exceptions.

When the law was changed to add new categories of beneficiaries or to increase benefits, savings clauses were included. The purpose of savings clauses was to prevent reduction of the benefits of individuals already on the rolls or to make sure they receive the full increase intended.

The entitlement of a divorced spouse to a spouse’s insurance benefit does not result in reducing the benefits of other categories of beneficiaries. Likewise, the entitlement of a legal spouse where a deemed spouse is also entitled does not affect the benefit of other beneficiaries entitled during the month. The other dependent’s or survivor’s insurance benefits are reduced for the maximum. The existence of the divorced spouse, surviving divorced spouse or legal spouse is not taken into account. His benefits are not reduced because of the family maximum.

The examples above, although not exhaustive, are the major exceptions to the family maximum currently in effect. They must be kept in mind in reading the next section. To avoid repetition, the examples are not restated each time they might be pertinent.

**Computing the family maximum adjustment.** The adjustment for the family maximum is made by proportionately reducing all monthly benefits subject to the family maximum on the
Social Security earnings record (except for retired worker’s or disabled worker’s benefits). All benefits subject to the family maximum are reduced in order to bring total monthly benefits payable within the limit for a particular case.

**When the adjustment is made.** This adjustment is made after any deductions that are applicable. It occurs when reduction for the family maximum is required, and a benefit payable to someone other than the worker must be withheld. Redistributing for the maximum is completed as though the beneficiary whose benefit must be withheld is not entitled to the amounts withheld.

The total benefits payable to the family group are not necessarily reduced when monthly benefits are not payable to one member of the family group.

**More than one benefit at the same time.** An individual may be entitled to more than one benefit at the same time. For example, an individual may be entitled to the parent’s insurance benefits on a deceased child’s Social Security earnings record and to a spouse’s insurance benefits on another record.

If an individual is entitled to more than one benefit, only the higher benefit is payable, unless one of the benefits is either (1) a retirement or disability insurance benefit, or (2) both benefits are child’s insurance benefits.

The lower benefit cannot be paid even if the higher benefit is not payable due to a suspension or deduction reason. However, if the higher benefit is terminated, the lower benefit will be reinstated automatically if still entitled.

**Example:** Mrs. Havitall is entitled to a spouse’s insurance benefit of $102.10 and a parent’s insurance benefit of $94.40. Her spouse’s insurance benefit is suspended for several months because of her husband’s work. Mrs. Havitall cannot be paid a parent’s insurance benefit for these months. However, if she gets divorced then her entitlement to spouse’s insurance benefits is terminated because she does not meet the requirements for receiving benefits as a divorced spouse. She would be entitled to parent’s insurance benefits. These will be paid to her, effective the month her spouse’s insurance benefits terminate.

**Entitlement to retirement or disability benefits and another benefit.** It is possible to be entitled to retirement or disability benefits as well as another higher benefit. In this case, the individual will receive the retirement or disability insurance benefit plus the difference between this benefit and the higher one. If the higher benefit is not payable, either in whole or in part for one or more months, the retirement or disability insurance benefit may be payable.

**Example:** Mrs. Martel is entitled to retirement insurance benefits of $128.10 and to spouse’s insurance benefits of $159.10. The total benefit payable to her is $159.10, made up of a retirement insurance benefit of $128.10 and a spouse’s insurance benefit of $31.00. If the spouse’s insurance benefit is not payable for some months because of her husband’s earnings, she will receive her own retirement insurance benefit of $128.10.
**Larger benefit can result.** In certain situations, beneficiaries who are eligible for benefits under multiple earnings records are better off with benefits based on the lower earnings records. This can be true in instances where the disability family maximum or a workers’ compensation offset exists. A larger total family benefit can result if one or more of the family member’s benefits are based on other smaller earnings records.
SELF-STUDY QUIZ

Determine the best answer for each question below. Then check your answers with the correct answers in the following section.

13. Assuming that all other conditions are met, which of the following individuals would be entitled to spousal benefits?
   a. Anna has a primary insurance retirement benefit that exceeds half of her husband’s primary insurance amount.
   b. Betty cares for a disabled child who is entitled to benefits on her husband’s Social Security record.
   c. Charlie has been married to Lucy for six months when he files an application for spousal benefits.
   d. Donna was married to her husband for nine years before her divorce became final.

14. Under what circumstances would a child’s benefit amount be three-fourths of the parent’s primary insurance amount?
   a. The parent is deceased.
   b. The parent is entitled to retirement benefits.
   c. The parent is entitled to disability benefits.
   d. The family maximum applies.

15. Megan receives child’s insurance benefits of $350 per month. She graduates from high school on May 12, and turns 18 on September 8. She has decided to pursue a modeling career instead of going to college. What amount of child’s insurance benefits does she receive for the current year?
   a. $1,400.
   b. $2,800.
   c. $3,150.
   d. $3,500.

16. What triggers an adjustment to the individual benefit rates paid on one Social Security earnings record?
   a. An individual is entitled to more than one benefit.
   b. An individual is entitled to disability benefits and another benefit.
   c. An individual is entitled to benefits under multiple earnings records.
   d. Benefits paid on one record exceed the family maximum.

17. Mrs. Brown is entitled to retirement insurance benefits of $152.20 and spouse’s insurance benefits of 174.10. How much is her total benefit?
   a. $174.10.
   b. $152.20.
SELF-STUDY ANSWERS

This section provides the correct answers to the self-study quiz. If you answered a question incorrectly, reread the appropriate material in this lesson. (References are in parentheses.)

13. Assuming that all other conditions are met, which of the following individuals would be entitled to spousal benefits? (Pages 37)

a. Anna has a primary insurance retirement benefit that exceeds half of her husband’s primary insurance amount. [This answer is incorrect. Because of her primary insurance retirement benefit, Anna is not eligible for benefits based on her husband’s Social Security record. If Anna’s primary insurance retirement benefit was less than half of her husband’s amount, then she would be entitled to spousal benefits.]

b. Betty cares for a disabled child who is entitled to benefits on her husband’s Social Security record. [This answer is correct. Per the Social Security Act, the spouse of an insured worker is entitled to benefits based on the worker’s Social Security record if the spouse is either (1) age 62 or over or (2) caring for a child who is under age 16 or disabled and entitled to benefits on the worker’s Social Security record.]

c. Charlie has been married to Lucy for six months when he files an application for spousal benefits. [This answer is incorrect. Charlie is not allowed to file an application for spousal benefits until he has been married to Lucy for at least one continuous year.]

d. Donna was married to her husband for nine years before her divorce became final. [This answer is incorrect. Divorced spousal benefits are different from spousal benefits. Being divorced from the worker is not part of the Social Security definition of a spouse that is used when determining spousal benefits. However, Donna is not entitled to divorced spousal benefits either, because she was not married to her ex-husband long enough. If she had been married to him for at least 10 years before the date the divorce became final, then Donna would have qualified for divorced spousal benefits.]

14. Under what circumstances would a child’s benefit amount be three-fourths of the parent’s primary insurance amount? (Page 40 and 43)

a. The parent is deceased. [This answer is correct. Per the Social Security Act, a child’s monthly benefit rate is three-fourths of the parent’s primary insurance amount under these circumstances.]

b. The parent is entitled to retirement benefits. [This answer is incorrect. Under these circumstances, the child would be entitled to a benefit of half of the insured parent’s primary insurance amount.]

c. The parent is entitled to disability benefits. [This answer is incorrect. In this situation, the child benefit amount equals half of the insured parent’s primary insurance amount.]

d. The family maximum applies. [This answer is incorrect. If the family maximum applies, the child benefit would be reduced. Since three-fourths of the parent’s primary insurance amount is the highest child benefit amount, this is not a reduction.]
15. Megan receives child’s insurance benefits of $350 per month. She graduates from high school on May 12, and turns 18 on September 8. She has decided to pursue a modeling career instead of going to college. What amount of child’s insurance benefits does she receive for the current year? (Page 43)

a. $1,400. [This answer is incorrect. This is the amount that Megan would receive if high school graduation was one of the events that triggers the termination of a child’s insurance benefit.]

b. $2,800. [This answer is correct. Since Megan is not entitled to benefits for the month in which she turns 18, she receives benefits for January–August, 8 x $350 = $2,800.]

c. $3,150. [This answer is incorrect. This is the amount that Megan would receive if she turned 18 in August instead of September.]

d. $3,500. [This answer is incorrect. This is the amount Megan would receive if she were receiving benefits as a disabled child. In that case, the benefits end with the second month following the month in which the disability ends.]

16. What triggers an adjustment to the individual benefit rates paid on one Social Security earnings record? (Page 44)

a. An individual is entitled to more than one benefit. [This answer is incorrect. If an individual is entitled to more than one benefit, only the higher benefit is payable, unless certain circumstances exist. Being entitled to more than one benefit does not automatically trigger an adjustment to the benefit rate.]

b. An individual is entitled to disability benefits and another benefit. [This answer is incorrect. It is possible to be entitled to retirement or disability benefits as well as another higher benefit. In this case, the individual will receive the retirement or disability insurance benefit plus the difference between this benefit and the higher one. However, the individual’s benefit rates are not automatically reduced if this situation occurs.]

c. An individual is entitled to benefits under multiple earnings records. [This answer is incorrect. Under certain circumstances, a larger total family benefit can result if one or more of the family member’s benefits are based on other smaller earnings records. However, being qualified under multiple earnings records does not require a benefit amount due to the individual to be reduced.]

d. Benefits paid on one record exceed the family maximum. [This answer is correct. Under the Social Security Act, a maximum family benefit is payable on a Social Security record. An adjustment is required whenever the total monthly benefits of all beneficiaries entitled on one Social Security earnings record exceed the family maximum that can be paid on that record for the month. All benefit rates (except retirement or disability insurance benefits and benefits payable to a divorced spouse or surviving divorced spouse) must be reduced to bring the total monthly benefits payable within the family maximum.]
17. Mrs. Brown is entitled to retirement insurance benefits of $152.20 and spouse’s insurance benefits of 174.10. How much is her total benefit? (Page 45)

a. $174.10. [This answer is correct. When someone is entitled to a retirement insurance benefit and another higher benefit, the individual receives the retirement insurance benefit plus the difference between that benefit and the higher one.]

b. $152.20. [This answer is incorrect. The total benefit is higher than $152.20. The retirement insurance benefit of $152.20 may be payable if the higher benefit isn’t payable for one or more months.]
EXAMINATION FOR CPE CREDIT

Lesson 3

Determine the best answer for each question below, then log onto our Online Grading System at cl.thomsonreuters.com/ogs to record your answers.

13. List all of the following individuals who are entitled to the full amount of spousal benefits, regardless of other considerations.

   Several members of Lisa’s family are entitled to Social Security benefits, so the family maximum applies.
   Vivian, age 55, is married to a retired worker and cares for a disabled child.
   Susan reaches full retirement age this year. In previous years, she elected to receive a reduced spousal benefit amount.
   Melanie is entitled to divorced spousal benefits.
   Kate receives a government pension and was not covered by Social Security.

   a. Vivian and Melanie.
   b. Kate and Susan.
   c. Lisa, Vivian, and Melanie.
   d. Lisa, Susan, and Kate.

14. Tony has four children. Assuming all of the other conditions are met, which one is entitled to child’s benefits on Tony’s Social Security record?

   a. Carla, age 17, is married.
   b. Angela, age 25, suffers a disability.
   c. Mike is 18 years old.
   d. Leo, age 19, is a full-time secondary school student.

15. Emily is the dependent child of Eddie. Eddie is disabled and receives quarterly disability payments of $2,700. What is Emily’s monthly benefit rate?

   a. $450.
   b. $675.
   c. $900.
   d. $1,350.
16. Which of the following benefits can be reduced when computing the family maximum?
   
i. The retired or disabled worker’s benefits.  iii. Child’s benefits.
   
   
a. i and iv.
   
b. ii and iii.
   
c. i, ii and iii.
   
d. i, ii, iii and iv.

17. Mrs. Head is entitled to more than one benefit, a spouse’s insurance benefit of $132.15 and a parent’s insurance benefit of $98.60. If she divorces Mr. Head, how much will her benefit payment be?
   
a. $0.
   
b. $98.60.
   
c. $132.15.
   
d. $230.75.
Lesson 4: Planning Considerations

Learning Objectives

Completion of this lesson will enable you to:

- Determine the advantages of taking Social Security benefits at various ages, the point at which Social Security benefits become taxable, and a strategy for dealing with possible taxation of benefits.

Deciding When to Start Receiving Benefits

Individuals approaching retirement age must decide whether to begin taking reduced benefits early or wait until full benefit retirement age (or later). For many individuals, the present value of the Social Security retirement benefits they would receive is similar under either option, depending on their life expectancy and tax bracket. Therefore, in many cases, this decision will depend on factors other than trying to receive the greatest lifetime benefit from Social Security.

Some individuals will delay retirement and continue to work because of personal preference. Yet others will want to retire early and will need to start receiving benefits as soon as possible.

Some individuals choose to take early Social Security benefits out of necessity—they are unemployed or underemployed, or they have an immediate financial need. Unfortunately, in many cases, taking the early, reduced benefit ensures their continued financial predicament. Studies suggest that those who take early benefits out of necessity often find themselves in even more desperate straits in later years as they continue to struggle on their permanently reduced benefit. For these people, early retirement may be a shortsighted, but necessary, solution.

Individuals in a better financial situation often have the luxury of waiting to allow their benefits to increase, thus ensuring a more comfortable retirement.

While individuals may have the option of retiring early and beginning to receive Social Security benefits immediately, the eligibility age for Medicare remains at 65. So, although they may be able to replace a sufficient amount of their earned income with Social Security benefits at age 62, they may not be able to adequately replace their employer-provided health insurance.

Taking Reduced Benefits at Age 62

Even if the retiree has sufficient funds to live without considering Social Security, some planners advise individuals to begin receiving benefits as soon as possible. For 2011, the benefits at age 62 are reduced by 25% of what they would be at age 66 (that is, the full benefit retirement age), but the individual will receive more Social Security checks if benefits are drawn early. In addition, drawing early Social Security benefits may allow the individual to leave tax-deferred retirement accounts untouched and growing for longer periods.

Individuals may want to receive benefits before their full benefit retirement age if they have dependents under age 18. Such dependents may be eligible for benefits if the individuals are also receiving Social Security benefits.
If an individual waits until the full benefit retirement age to draw benefits and the primary insurance amount (PIA), which is a function of his earnings history, remains the same, it will take around 12 years to reach the break-even point to make up for the years of payments that were not received.

Most break-even analysis compares only the Social Security benefits. It does not consider the forgone investment income which could have been earned from age 62 until full retirement on the early benefits or the compounded future value of that sum.

An individual’s life expectancy should be considered when determining the starting date for Social Security benefits. If the individual does not expect to live beyond twelve years after early retirement, he will receive more benefits by taking the reduced monthly payment.

If the present value of future Social Security benefits is considered, it would normally be more favorable to start the benefits as soon as possible. However, if the individual is simply using early Social Security benefits to replace a similar amount of earned income, his short-term position will not be improved and his long-term outlook will suffer.

Waiting until Full Benefit Retirement Age

Retirees should carefully consider the long-lasting advantages of waiting until their full benefit retirement age before drawing Social Security benefits. Factors to consider include:

1. Life expectancy.
2. Shortening the retirement period.
3. The earnings test.
4. Replacing earlier lower-wage years with later higher-wage years.
5. The compounding of inflation adjustments on a higher base.
6. Effect on the retiree’s spouse.

**Life expectancy.** The individual’s life expectancy may be the biggest factor in deciding whether he should receive Social Security benefits early. While tables and averages are available, a 62-year-old individual should have a good idea of his own life expectancy. His current health and the longevity of his parents should be clearly established by that age. In general, 80 years might be a good cutoff point. If the individual reasonably expects to reach that age, waiting until the full benefit retirement age may be a wise choice.

**Shortening the retirement period.** A significant factor in retirement planning projections is the length of the retirement period, computed as follows:

\[
\text{Length of Retirement Period} = \text{Life Expectancy} - \text{Age at Retirement}
\]

**Example:** Nancy wants to retire at age 62 and has a life expectancy of 85. She has a 23-year retirement period to fund. By working past age 62, Nancy is shortening her retirement period and decreasing the resources needed to fund her retirement, regardless of her longevity.
The earnings test. Individuals who are considering receiving Social Security retirement benefits before their full benefit retirement age, but who also intend to keep working, must consider the earnings test. For 2011, the exempt amount is $14,160 (for years before reaching their full benefit retirement age). This means that Social Security benefits are reduced $1 for every $2 in earnings above that exempt amount. Individuals already facing a reduced benefit amount because of their early retirement would have their benefits reduced even further by failing the earned income test.

Replacing lower-wage years. An individual’s Social Security benefits are based on his primary insurance amount (PIA). The PIA is calculated from the individual’s highest earnings during a 35-year calculation period. If an individual can replace lower-wage years early in his career with higher-wage years after age 62, he can increase his PIA. This can lead to a dramatically higher retirement benefit when the individual retires. A higher PIA will also increase disability and survivor’s benefits.

The effect on the spouse. The individual’s decision to start receiving Social Security benefits before reaching the full benefit retirement age may also affect a spouse’s benefits. Unless the spouse has his own earnings record and is fully insured, he will be dependent on his working spouse’s PIA for retirement benefits. A spouse who is not fully insured and who waits until his full benefit retirement age is eligible to receive 50% of the worker spouse’s retirement benefit. However, a worker who retires early may have a lower PIA than if he had waited until his full benefit retirement age. Therefore, his spouse’s benefit would be based on that lower PIA.

Example: Charlie retired in 2010 at age 63. In 2011, he decides to work part-time and earns wages of $15,160, $1,000 over the exempt amount. Charlie has investment income and is in the 25% marginal tax bracket. His Social Security benefits are subject to tax, and 85% of the benefits are included in his gross income. Since Charlie is under the full benefit retirement age, his benefits are reduced $1 for every $2 he earns over the exempt amount. Charlie’s additional spendable portion of the $1,000 after considering taxes and the loss of Social Security benefits is only $279.75, shown as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings over the exempt amount</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>Social Security tax on $1,000 (7.65%)</td>
<td>(76.50)</td>
</tr>
<tr>
<td>Income tax on $1,000</td>
<td>(250.00)</td>
</tr>
<tr>
<td>Loss of Social Security benefits ($1,000 ÷ 2)</td>
<td>(500.00)</td>
</tr>
<tr>
<td>Tax savings because of $500 reduction in Social Security benefits ($500 × 85% × 25%)</td>
<td>106.25</td>
</tr>
<tr>
<td>Additional spendable amount</td>
<td>$279.75</td>
</tr>
</tbody>
</table>

Beginning Benefits after Reaching Full Benefit Retirement Age

An individual who works past his full benefit retirement age receives larger benefits because of the delayed retirement credit. A worker born in 1943 or later receives a credit of 8% per year for each year he delays receiving benefits after reaching his full retirement benefit age until age 70.
Social Security Benefit Calculators

Prior to retirement, individuals should calculate the Social Security benefit likely to be received upon retirement. In doing so, they will need to project earnings for the remaining period of time before retirement. Taxpayers may do this exercise frequently because they want to know how their benefits will be affected by either an increase or decrease in future earnings. They may also want to calculate the benefits in the event of early or postponed retirement.

How Social Security Benefits are Taxed

According to the SSA, about one-third of people who receive Social Security retirement, survivorship or disability payments must pay taxes on their benefits. This provision affects only people who have substantial income in addition to their Social Security, including:

1. Those with single filing status and a provisional income:
   a. Between $25,000 and $34,000 may have to pay taxes on 50% of their benefits, or
   b. Above $34,000 are liable for income tax on up to 85% of their benefits.

2. Those with joint filling status and a provisional income of:
   a. Between $32,000 and $44,000 may have to pay taxes on 50% of their benefits, or
   b. Above $44,000 are liable for income tax on up to 85% of their benefits.

Provisional income equals adjusted gross income (AGI) (as reported on Form 1040), plus nontaxable interest plus half of the taxpayer’s Social Security benefits.

For individuals with very low or very high incomes, planning to reduce or avoid the tax on Social Security benefits is either unnecessary or unrealistic. Either none or 85% of benefits will be includable in gross income. However, there is a middle tier group for whom no more than 50% of benefits is includable. Planning is most beneficial for those in the middle group.

The key to planning is income deferral, not necessarily income avoidance. Popular methods for creating deferred income include the purchase of Series EE bonds (on which the interest income need be reported only when the bonds are redeemed), single-premium annuities (on which tax is avoided until withdrawals begin) and certain securities (which produce taxable gain when sold).

Analysis. If provisional income is less than $25,000 [$32,000 for married filing jointly (MFJ)], none of the Social Security benefits are taxable. However, any increase in income that raises provisional income over this limit will result in inclusion of Social Security benefits in taxable income. If provisional income is greater than $25,000 ($32,000 for MFJ) but not over $34,000 ($44,000 for MFJ), then 50% of the excess provisional income becomes taxable until 50% of Social Security benefits have been included. For those in this income range, each additional $100 of pre-Social Security income results in an additional $150 of taxable income and an additional $22.50 of tax (assuming the 15% marginal tax bracket). This represents an effective tax rate of 22.5% (1.5 × 15%) on that additional income. This rate should affect all decisions and strategies until 50% of Social Security benefits have been included in income.
When provisional income exceeds $34,000 ($44,000 for MFJ), 85% of the excess provisional income will be taxable until 85% of Social Security benefits have been included. For those in this income range, each additional $100 of pre-Social Security income results in an additional $185 of taxable income and an additional $27.75 of tax (again, assuming the 15% marginal tax bracket). This represents an effective tax rate of 27.75% (1.85 × 15%) on that additional income. This rate would affect all decisions and strategies until 85% of Social Security benefits have been included in income. At that point, the marginal rate would return to 15%.

**Planning Strategies**

**Paying off the mortgage.** Frequently, taxpayers consider mortgage interest to be one of the last available tax deductions. Rather than pay off a mortgage, many taxpayers will keep investments which produce income greater than or close to the rate of interest which they pay on the mortgage. If they earn 6% on the investment and pay 6% on the mortgage, in their opinion, this results in a breakeven situation.

However, taxpayers in the phase-in range for including Social Security benefits, could reduce taxable income by using the investment funds to pay off the mortgage. If the taxpayer is in the 85% phase-in range, then the tax savings could be as much as 21.25% (85% of 25%—the assumed tax bracket).

For taxpayers using the standard deduction, the tax savings could be as much as 27.75%, as shown in the example below.

**Example:** Ed and Wilma are married, both are 65 years old and receiving $20,000 in Social Security benefits. They earn interest income of $6,000. They itemize their deduction, including mortgage interest of $6,000 on Schedule A. They are in the 15% tax bracket. Taxable income is unaffected by the interest income since it is offset by the mortgage interest deduction.

If they liquidated the investment which earns interest of $6,000 and used the proceeds to pay off the mortgage, there could be a tax savings of $765. This results from the fact that the $6,000 of interest income may be causing $5,100 of Social Security benefits to be taxed (85% of $6,000). The tax savings would be $765 at 15%.

If they were not itemizing deductions, then the tax savings would be $1,665 (15% of $5,100 plus 15% of $6,000).

The overall savings could be greater if the rate of interest on the mortgage is greater than the interest earned on the liquidated investment.

**Charitable contributions of appreciated property.** When taxpayers contribute appreciated long-term capital gain property, they get a deduction equal to the property’s FMV without having to include as income the difference between the FMV and the basis.

If the same property were sold and the proceeds given to charity, the resulting gain must be included in income. While the contribution of the proceeds creates a tax deduction, the inclusion of the gain would cause more Social Security to be taxable for taxpayers in the phase-in range.
**Pension plan distributions.** At age 59½, taxpayers generally can enjoy distributions from their pension plans in whatever amounts they choose without penalty. With the exception of Roth IRAs, such distributions are taxable income. Once taxpayers achieve age 70½, they are generally required to take required minimum distributions (RMDs) from IRAs and other retirement plans.

By reducing or eliminating distributions from retirement plans, to the extent possible under the RMD rules, taxpayers can defer tax on the distribution and can avoid tax that would otherwise result from increased income due to the phase-in rules for Social Security.

**IRA contribution.** Social Security recipients who also have earned income can make contributions to an IRA up to $5,000 for 2011 plus an additional $1,000 if they are over age 50. Income taxation of Social Security benefits can make IRA contributions more attractive since they reduce the amount of the Social Security that must be included as income for taxpayers who are in the phase-in range. Further, married taxpayers where at least one spouse has adequate earned income could take advantage of the spousal IRA and thereby double the deduction.

A traditional IRA contribution cannot be made in the year the individual turns 70½. Those individuals who are still working into their 70’s may be able to take advantage of their employer plans. While they are subject to the RMD requirement, SEPs and SIMPLE IRAs are not subject to the age 70½ contribution prohibition and, potentially, they can be used to help self-employed seniors reduce their taxable AGI.

**Bunching or smoothing.** Frequently, taxpayers can control the timing for receipt of income. Income may be bunched into one year or may be received smoothly over a number of years. By bunching income into a year when the taxpayer has already received sufficient income to the point that 85% of Social Security is being taxed, they may reduce income in a previous or succeeding year, resulting in excluding more Social Security from taxable income in those years.

A similar result can be obtained by bunching items which would result in adjustments to income. However, taxation of Social Security benefits will not be affected by timing of itemized deductions.
SELF-STUDY QUIZ

Determine the best answer for each question below. Then check your answers with the correct answers in the following section.

18. When planning for retirement, individuals must decide whether to take reduced Social Security benefits at age 62 or wait until their full benefit retirement age. In which of the following circumstances would it be advantageous to take the reduced payout?
   a. The benefits will replace the same amount of the individual’s earned income.
   b. The individual will continue to work after retirement and earn $15,000 per year.
   c. The individual does not expect to live more than 12 years.
   d. The individual was paid lower annual wages early in his career.

19. Tom, an avid golfer and motorcycle enthusiast, has decided to retire at age 62 to devote more time to his hobbies. Tom’s wife continues to work until her full benefit retirement age. How will Tom’s early retirement affect his wife’s benefits?
   a. Her benefit amount will be reduced even if she is fully insured through her employer.
   b. Her benefit amount will be reduced if she is not fully insured.

20. Jason, age 75, receives Social Security benefits. He also receives additional income from a variety of other sources. In 2011, he will receive enough additional income that 85% of his Social Security income will be taxed. What planning strategy would be the most helpful in Jason’s situation?
   a. Bunch as much additional income into 2011 as possible.
   b. Donate appreciated property to charity.
   c. Pay off his mortgage.
   d. Defer any distributions from IRAs or retirement plans.
SELF-STUDY ANSWERS

This section provides the correct answers to the self-study quiz. If you answered a question incorrectly, reread the appropriate material in this lesson. (References are in parentheses.)

18. When planning for retirement, individuals must decide whether to take reduced Social Security benefits at age 62 or wait until their full benefit retirement age. In which of the following circumstances would it be advantageous to take the reduced payout? (Page 54)

   a. The benefits will replace the same amount of the individual’s earned income. [This answer is incorrect. If the present value of future Social Security benefits is considered, it would normally be more favorable to start the benefits as soon as possible. However, if the individual is simply using early Social Security benefits to replace a similar amount of earned income, his short-term position will not be improved and his long-term outlook will suffer. Therefore, this is not a situation in which it is advantageous to take the earlier payout.]

   b. The individual will continue to work after retirement and earn $15,000 per year. [This answer is incorrect. Individuals considering receiving Social Security retirement benefits before their full benefit retirement age, but who also intended to keep working, must consider the earnings test. For 2010, the exempt amount is $14,160 (for years before reaching their full retirement age). This means that Social Security benefits are reduced $1 for every $2 in earnings above that exempt amount. Individuals already facing a reduced benefit amount because of their early retirement would have their benefits reduced even further by failing the earned income test. Therefore, under these circumstances, taking the earlier payout would not be advantageous.]

   c. The individual does not expect to live more than twelve years. [This answer is correct. An individual’s life expectancy should be considered when determining the starting date for Social Security benefits. If the individual does not expect to live beyond twelve years after early retirement, he will receive more benefits by taking the reduced monthly payment. If an individual waits until the full benefit retirement age to draw benefits and the primary insurance amount (PIA) remains the same, it will take around 12 years to reach the break-even point to make up for the years of payments that were not received.]

   d. The individual was paid lower annual wages early in his career. [This answer is incorrect. An individual’s Social Security benefits are based on his PIA. The PIA is calculated from the individual’s highest earnings during a 35-year calculation period. If an individual can replace lower-wage years early in his career with higher-wage years after age 62, he can increase his PIA. Thus, these circumstances do not make it advantageous to take the early payout.]
19. Tom, an avid golfer and motorcycle enthusiast, has decided to retire at age 62 to devote more time to his hobbies. Tom’s wife continues to work until her full benefit retirement age. How will Tom’s early retirement affect his wife’s benefits? (Page 55)

a. Her benefit amount will be reduced even if she is fully insured through her employer. [This answer is incorrect. Since Tom’s wife is fully insured through her own employer, she isn’t relying on Tom’s PIA; thus, his early retirement has no effect on her benefits.]

b. Her benefit amount will be reduced if she is not fully insured. [This answer is correct. A spouse who is not fully insured is eligible to receive 50% of her husband’s retirement benefit if he waits to retire until his full benefit retirement age. Since Tom is retiring early, he may have a lower PIA than if he had waited until his full benefit retirement age. Thus, his wife’s benefit will be based on the lower PIA.]

20. Jason, age 75, receives Social Security benefits. He also receives additional income from a variety of other sources. In 2011, he will receive enough additional income that 85% of his Social Security income will be taxed. What planning strategy would be the most helpful in Jason’s situation? (Pages 58)

a. Bunch as much additional income into 2011 as possible. [This answer is correct. Frequently, taxpayers can control the timing for receipt of income. Income may be bunched into one year or may be received smoothly over a number of years. By bunching income into a year when he has already received sufficient income to the point that 85% of Social Security is being taxed, Jason may reduce income in a previous or succeeding year, resulting in excluding more Social Security from taxable income in those years.]

b. Donate appreciated property to charity. [This answer is incorrect. When taxpayers contribute appreciated property, they get a deduction equal to the fair market value without having to include as income the difference between the fair market value and the basis. If the same property were sold and the proceeds given to charity, the resulting gain must be included in income. However, while this is a valid planning strategy, it is not applicable in Jason’s situation, as described above, because Jason is not making charitable donations.]

c. Pay off his mortgage. [This answer is incorrect. If the taxpayer is in the phase-in range for including Social Security benefits, they could reduce taxable income by using the investment funds to pay off the mortgage. However, because Jason’s additional income comes from a variety of sources, this planning strategy would not necessarily be enough to get him out of the 85% tax bracket. A different planning strategy would be more helpful in Jason’s situation.]

d. Defer any distributions from IRAs or retirement plans. [This answer is incorrect. If Jason were younger (e.g., 59½), this would be a valid planning strategy. However, once taxpayers reach age 70½, they are generally required to take minimum distributions from IRAs and other retirement plans.]
EXAMINATION FOR CPE CREDIT

Lesson 4

Determine the best answer for each question below, then log onto our Online Grading System at cl.thomsonreuters.com/ogs to record your answers.

18. Samuel was born in 1943. He would like to maximize his Social Security benefits by receiving the allowed credit of 8% per year for the maximum number of years. What year should Samuel retire?
   a. 2010.
   b. 2011.
   c. 2013.
   d. 2015.

19. Tim’s filing status for income tax purposes is single. He earned $21,000 in 2010, including $1,000 in taxable interest, and received $6,000 in Social Security benefits. What percentage of his Social Security benefits may be taxable?
   a. 0%.
   b. 15%.
   c. 50%.
   d. 85%.

20. Laurence and Beth are married taxpayers who file jointly. Their annual income is $60,000, and they also receive Social Security benefits. What percentage of their Social Security benefits will be taxable?
   a. 0%.
   b. 15%.
   c. 50%.
   d. 85%.
Lesson 5: Survivor’s and Disability Benefits

Learning Objectives

Completion of this lesson will enable you to:

- Identify various survivor benefits and their qualification requirements, as well as disability benefits and their eligibility requirements.

Survivor’s Benefits

When the insured worker dies, cash benefits may be paid to an eligible survivor as:

1. Monthly widow(er)’s insurance benefits,
2. Monthly surviving child’s insurance benefits,
3. Monthly father’s or mother’s insurance benefits,
4. Monthly parent’s insurance benefits, and/or
5. Lump-sum death payment.

Benefits rates are figured as a percentage of the deceased worker’s primary insurance amount.

Widow(er)’s Benefits

Benefit Rate

The widow(er)’s insurance benefit rate equals 100% of the deceased worker’s primary insurance amount plus any additional amount the deceased worker was entitled to because of delayed retirement credits.

When the rate may be reduced. The widow(er)’s insurance benefit payable may be less than what was computed above if any of the conditions below apply:

1. A reduction is necessary because the family maximum applies.
2. The widow(er) is also entitled to a smaller retirement insurance or disability insurance benefit [only the difference between the larger widow(er)’s insurance benefit and the other benefit is payable as the widow(er)’s insurance benefit; however, this amount is payable in addition to the other benefit].
3. The worker or spouse was receiving benefits before the month they reached retirement age.
4. The widow(er) chooses to receive and is paid a reduced benefit for months before reaching retirement age. A reduced benefit rate is payable for as long as that individual is entitled to widow(er)’s benefits.

Entitlement to this reduced rate may result in a reduction in any disability or retirement insurance benefit to which they may later become entitled.
5. The widow(er) is caring for the deceased spouse’s child and:
   a. The child is under age 16 or disabled,
   b. The child is entitled to child’s insurance benefits, and
   c. The widow(er) has not reached retirement age. In this case, the widow(er)’s benefits are not reduced for those months below 75% of the deceased spouse’s primary insurance amount.

6. The deceased worker was entitled to a reduced retirement benefit for the month before the month he died.

Who Is Entitled to the Benefit?

Individuals are entitled to widow(er)’s insurance benefits on a worker’s Social Security record if:

1. They are either (a) age 60 or over, or (b) at least age 50 but not age 60 and disabled and they meet the disability-related requirements [a widow(er) age 60–64 and under a disability is entitled to disabled widow(er)’s benefits for Medicare purposes];
2. The worker died fully insured;
3. They are not entitled to a retirement insurance benefit that is equal to or larger than the worker’s primary insurance amount;
4. They have filed an application for widow(er)’s insurance benefits; and
5. They are not married or their marriage can be disregarded (see below for exceptions), and any of the following conditions is met:
   a. They were married to the deceased worker for at least nine months just before the worker died;
   b. They are the parent of the worker’s son or daughter [this requirement is met if a live child was born to widow(er) and the worker, even if the child did not survive];
   c. They legally adopted the worker’s son or daughter during their marriage to the worker and before the child reached age 18;
   d. They were married to the worker when they both legally adopted a child under age 18;
   e. The worker legally adopted their son or daughter during their marriage and before the child reached age 18; or
   f. In the month before the month they married the deceased worker, they were entitled or potentially entitled to either (i) spouse’s, widow(er)’s, parent’s or childhood disability benefits on the record of a fully insured individual under the Social Security Act, or (ii) widow(er)’s, child’s (age 18 or over) or parent’s insurance annuity under the Railroad Retirement Act.

Exception to nine-month duration of marriage requirement. The nine-month duration of marriage requirement above is waived if the widow(er) was married to the insured worker at the time of his death and:

1. The insured worker’s death was accidental;
2. The insured worker’s death occurred in the line of duty while he was a member of a uniformed service serving on active duty;
3. The widow(er) was previously married and divorced from the insured worker and the previous marriage had lasted at least nine months; or

4. Effective for applications filed in or after March 2004:
   a. The insured worker had been married prior to his marriage to the widow(er);
   b. The prior spouse was institutionalized during the insured worker’s marriage to him due to mental incompetence or similar incapacity;
   c. During the period of the prior spouse’s institutionalization, the insured worker would have divorced the prior spouse and married the surviving spouse, but did not do so because the divorce would have been unlawful, by reason of the institutionalization, under the laws of the state of the insured worker’s domicile at the time (this determination is based on evidence satisfactory to the SSA);
   d. The prior spouse remained institutionalized up to the time of his death; and
   e. The insured worker married the widow(er) within 60 days after the prior spouse’s death.

The exceptions to the nine-month duration of marriage requirement in 1, 2 and 3 above do not apply if, at the time of the marriage, the insured worker could not reasonably have been expected to live for nine months.

**Surviving divorced husband or wife.** Individuals are entitled to surviving divorced spouse’s insurance benefits on the deceased worker’s Social Security record if:

1. They are either (a) age 60 or over, or (b) at least age 50 but not age 60 and disabled and they meet the disability-related requirements.
2. The worker died fully insured.
3. They are not married (see below for exceptions).
4. They meet the requirements in 3 and 4 under “Widow(er)’s Benefits” above.

Individuals are surviving divorced wives or husbands if they were married to the worker for at least 10 years just before the date the divorce became final. They meet this definition even if they were divorced within the 10-year period, provided they remarried the worker no later than the calendar year after the year of the divorce.

**Effect of Remarriage**

A remarriage after age 60 does not prevent someone from becoming entitled to benefits on their prior deceased spouse’s Social Security earnings record.

**Disabled widow(er) or surviving divorced spouse.** A remarriage does not prevent individuals from becoming entitled to benefits on their prior deceased spouse’s Social Security earnings records as long as:

1. The remarriage occurs after they turn 50, and
2. The remarriage occurs after they become disabled.

If they remarry before turning 50, they will not be entitled to survivor’s benefits, unless the marriage ends.
Entitlement is not affected if they enter into a same-sex marriage or union. The SSA does not recognize the marriage for benefit purposes.

**Remarriage before age 60.** If someone remarries before age 60, they will not be entitled to survivor’s benefits, unless:

1. The subsequent marriage ends, whether by death, divorce or annulment; or
2. The marriage occurred after age 50 and they were entitled to benefits as a disabled widow(er) or disabled surviving divorced spouse.

**Termination of a remarriage before age 60.** If individuals remarry before they turn 60 and that marriage ends, they may become entitled or re-entitled to benefits on their prior deceased spouse’s earnings record. The benefits begin the first month in which the subsequent marriage ended if all entitlement requirements are met.

**Application Requirement**

Individuals do not need to file an application for widow(er)’s benefits if:

1. They have reached retirement age and were entitled to spouse’s benefits for the month immediately before the month that their spouse died.
2. They were entitled to father’s or mother’s benefits for the month immediately before the month they reached retirement age.
3. They were (a) between ages 62 and retirement age at the time their spouse died, and (b) entitled to spouse’s benefits, but not to disability or retirement benefits. The spouse’s benefits are automatically converted to widow(er)’s insurance benefits.

A certificate of election to become entitled to widow(er)’s benefits must be filed if an individual is:

1. Receiving reduced spouse’s (or divorced spouse’s) benefits and retirement or disability benefits in the month before the month of the worker’s death, and
2. Between age 62 and retirement age in the month of the worker’s death.

**Termination of Widow(er)’s Benefits**

An individual’s widow(er)’s insurance benefits end when:

1. He dies.
2. He becomes entitled to a retirement insurance benefit that is equal to or larger than the worker’s primary insurance amount.
3. His disability ends. In this case, his last month of entitlement is the second month after the month in which disability ended. However, his entitlement continues if he reaches retirement age on or before the last day of the third month after his disability ended.

Individuals are not entitled to widow(er)’s benefits for the month in which any one of the above events occurs, except as explained in item 3 above.

Benefits will not terminate or be reduced upon remarriage if the recipient is a:

1. Widow(er) or surviving divorced wife or husband age 60 or over.
2. Disabled widow(er) or disabled surviving divorced wife or husband age 50 or over.
Surviving Child’s Benefits

Benefit Rate

The surviving child’s insurance benefit rate is 75% of the deceased parent’s primary insurance amount.

When the rate may be reduced. The child’s insurance benefit may be less than above if the family maximum applies and all the benefits on that earnings record have to be reduced.

Who Is Entitled to the Benefit?

A surviving child is entitled to child’s insurance benefits if:
1. The worker-parent died either fully or currently insured.
2. The child is the child of the deceased.
3. The child is:
   a. Under age 18,
   b. Under age 19 and a full-time elementary or secondary school student, and
   c. Age 18 or over and under a disability (which began before age 22).
4. The child was dependent upon the deceased parent.
5. The child is not married.
6. An application for child’s insurance benefits is filed.

An application is not required if the child was entitled to child’s insurance benefits on the deceased parent’s earnings record for the month before the month in which the parent died.

Definition of a child. The term child includes the insured worker’s:
1. Natural (that is, biological) legitimate child, or any other child who would have the right under applicable state law to inherit intestate personal property from the insured worker as his child.
2. Stepchild, under certain circumstances.
3. Legally adopted child.
4. Child of an invalid ceremonial marriage entered into under certain conditions.
5. Natural child, provided the insured worker:
   a. Has acknowledged in writing that the child is his son or daughter.
   b. Has been decreed by a court to be the parent of the child.
   c. Has been ordered by a court to contribute to the support of the child because the child is his son or daughter.
   d. Has been shown to be the child’s father or mother by other reasonable evidence. The worker must have lived with the child or contributed to the child’s support when the insured worker died.
6. Dependent grandchild or step-grandchild.
   The court action in item 5 above must be made before the worker’s death.
When the Child’s Benefit Is Not Payable

The child’s insurance benefit may not be payable for some months if any of the conditions below are met:

1. The child works and earns more than the yearly exempt amount.
2. The child works outside the U.S. for more than 45 hours per month.
3. The child is an alien who is outside the U.S. for more than six calendar months in a row and does not meet an exception to the alien non-payment provision or does not meet the additional U.S. residency requirements for dependents and survivors.
4. The insured parent had been deported, and the child is an alien who is outside the U.S.
5. The disabled child, age 18 or older, refuses to accept vocational rehabilitation services without good cause.
   The child’s insurance benefit may be payable for all months while the disabled child is still under age 19, if a full-time student.
6. The disabled child, age 18 or older, is married to a retirement insurance beneficiary whose benefit is not payable because of work activity.
7. The disabled child, age 18 or older, is married to a disability insurance beneficiary whose benefit is not payable because of refusal to accept vocational rehabilitation services without good cause.
8. The child is confined within the U.S. in a jail, prison or other penal institution or correctional facility for conviction of a felony.
   The benefit may still be payable if the child is participating in a rehabilitation program that has been specifically approved for the child by a court of law. It must be expected that the child will be able to engage in substantial work upon release within a reasonable time.
9. The child does not have a Social Security number, and the child or his parent, guardian or individual acting on the child’s behalf refuses to apply for one.
10. The child is in the U.S. and is neither a U.S. citizen nor a lawfully present alien.

When Child’s Benefits End

Surviving child’s insurance benefits end when any of the conditions below are met:

1. The child dies.
2. The child reaches age 18 and is neither under a disability nor a full-time elementary or secondary school student.
   Entitlement to childhood disability benefits ends when the child age 18 or older is no longer under a disability that began before age 22. However, benefits may continue if the child is still under age 19 and a full-time elementary or secondary school student.
3. The child marries. Exceptions: Benefits do not end if a disabled child age 18 or over marries another Social Security beneficiary or if the marriage is absolutely void or has been annulled from the beginning.
4. The child’s entitlement is based on a legal adoption and the adoption is annulled.
5. The child is a stepchild of the worker, and the marriage between the worker and the stepchild’s parent ends in divorce.

The effective date of the termination of benefits is the month in which any of the above events occurs. However, a disabled child’s benefits terminate effective with the second month following the month in which he is no longer under a disability. Also, a stepchild’s benefits terminate effective with the month after the divorce becomes final.

**Lump-sum Death Benefit**

A lump-sum death payment may be made on the Social Security record of a worker who dies either fully or currently insured. The lump-sum is a one-time payment of $255. It is paid in addition to any monthly survivor’s insurance benefits that are due.

**Types of Disability Protection**

Under Social Security, the following individuals might receive disability benefits:

- Disabled individuals.
- Family members of a disabled worker.
- Individuals with a disabled child.
- Disabled widow(er)s.

Social Security provides the following types of disability protection:

1. *Cash benefits for a disabled worker and family.* These are often referred to as disability insurance benefits. However, in this lesson they are called disabled worker’s benefits to distinguish them from other benefits for disabled individuals.

2. *Cash benefits for the needy, blind or disabled,* including blind or disabled children under the Supplemental Security Income (SSI) program.

3. *A period of disability.* This protects against the loss or reduction of the disability amount or retirement insurance benefits for the worker and his survivors. A period of disability excludes the time the worker is disabled for determining either insured status or the amount of benefits. This protects workers since it is likely that they do not have substantial earnings when disabled. The requirements for disabled worker’s benefits and for establishing a period of disability are nearly the same. A worker entitled to either one is usually entitled to both.

4. *Cash benefits for a disabled widow(er) or disabled surviving divorced spouse.* These apply to disabled widow(er)s (or disabled surviving divorced spouses) age 50–59 who meet the other requirements for entitlement to widow(er)’s insurance benefits. Statements in this lesson that apply equally to disabled widow(er)’s and disabled surviving divorced spouses refer to them simply as disabled widow(er)s.

5. *Cash benefits for a disabled child* are payable as early as age 18, and there is no upper age limit. They are referred to as childhood disability benefits because the child must have become disabled before reaching age 22.
6. **Vocational rehabilitation service/other support services** help beneficiaries obtain the services and assistance they need to go to work. A state vocational rehabilitation agency or an employment network provides these services.

7. **Hospital and supplementary medical insurance protection** for:
   a. Individuals under age 65 who have been entitled to disability benefits as a disabled worker, widow(er) or adult child for at least 24 months.
      The individual must be entitled to benefits on the basis of insured status established under the Social Security Act.
   b. Individuals who have chronic kidney failure requiring a regular course of dialysis or a kidney transplant or are disabled due to Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease) and are entitled to disabled worker benefits, are fully insured, currently insured or entitled to monthly insurance payments because of work covered by the Social Security Act or the Railroad Retirement Act. This includes the spouse or dependent child of a person who is insured or entitled to monthly benefits payable under these Acts.
   c. Individuals whose disability did not end before December 1, 1980. The beneficiary may have his medical coverage continued for a maximum of 24 months after entitlement ends based on disability, provided medical recovery has not occurred.
      After this period, individuals may elect to purchase premium Medicare coverage. This is provided if they continue to have a disabling impairment, file during an enrollment period and their premium-free Medicare coverage ended because of substantial gainful activity.

8. **Prescription drug benefit** for individuals entitled to hospital insurance or enrolled in supplementary medical insurance.

**Defining Disability**

An individual who meets all the following conditions is considered disabled and entitled to disabled worker's benefits:

1. He is unable to engage in any substantial gainful activity because of a physical or mental impairment. He must not only be unable to do his previous work, but also any other type of work considering his age, education and work experience.
   It does not matter whether such work exists in the individual’s immediate area, whether a specific job vacancy exists or whether that individual would be hired if he applied for work.

2. His impairments must be established by objective medical evidence.

3. It is expected that his impairments will either result in death or last for at least 12 months in a row.

4. He must meet the non-medical criteria needed to be insured by the program.

Individuals will not be found disabled if they are physically and mentally able to do any of their past relevant work or any other kind of work that exists in significant numbers in the U.S. economy. The SSA will find that an individual is not disabled even if he cannot do any of his
past relevant work, if he can adjust to other work consisting of jobs that exist in significant numbers. The jobs must exist in the national economy, either in the region where the individual lives or in several regions of the country.

**Blindness.** For Social Security purposes, blindness as a disability is either:

1. Central visual acuity of 20/200 or less in the better eye with the use of a correcting lens, or
2. A limitation in the field of vision such that the widest diameter of the visual field in the better eye is an angle of 20 degrees or less.

**Age 55 and older.** Under Title II, there is a special rule for a blind worker who is at least 55. Individuals are considered disabled if, by reason of such blindness, they cannot engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity that they previously engaged in with some regularity and over a substantial period of time.

No benefits are payable for any month that an individual engages in substantial gainful activity.

**Felons.** Under Title II, individuals who committed a felony after October 19, 1980, are not entitled to disability cash benefits if:

1. Their impairments (or the aggravation of preexisting impairments) are related to their commission of the felony, or
2. Their impairments (or the aggravation of preexisting impairments) are related to their confinement in a correctional facility for the conviction of the felony.

Although individuals may not be eligible for cash benefits, their confinement-related impairments and impairments aggravated by their confinement may be used to establish a period of disability. They can apply to have their Social Security records show how long they are disabled. If a period of disability is established, the months in that period of time are not counted in computing their average earnings for any future benefits.

**Drug and alcohol abusers.** For both Title II and Title XVI, individuals cannot be considered disabled if drug or alcohol abuse is a contributing factor of disability. This is true regardless of age.

**Medically Determinable Impairment**

A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological or psychological abnormalities, which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms and laboratory findings, not only by the individual’s statement of symptoms.

**Twelve-month duration requirement.** To meet the duration requirement, the medically determinable physical or mental impairment must be expected to result in death, or must have lasted or can be expected to last for at least 12 months in a row. The duration requirement may be met, even though recovery is expected to occur after the 12-month period, provided the individual’s impairment keeps him from engaging in substantial gainful activity for at least 12 months in a row.
**Substantial Gainful Activity**

An individual doing substantial gainful activity is not considered disabled. Work activity does not need to be performed on a full-time basis to be substantial. An individual engaged in substantial gainful activity cannot receive disability benefits unless one of the following exceptions is met:

**Exception #1.** A statutorily blind worker age 55 or older is not prevented from establishing a period of disability or being considered for entitlement to benefits if there is evidence of his ability to do substantial gainful activity that does not require skills or abilities comparable to any gainful activity that that individual did in the past. Disabled worker’s benefits are not payable for months an individual actually does substantial gainful activity.

**Exception #2.** A statutorily blind applicant’s ability to do substantial gainful activity does not prevent a finding of blindness. However, earnings are considered under the income and resources provisions. This provision also applies to children under age 18.

**Work performance.** Satisfactory work performance during a period of disability may indicate that an individual can do substantial gainful activity. The SSA considers all the medical and vocational evidence in an individual’s file to determine if he has the ability to work.

**Make work.** Performing make work does not show that an individual is able to do substantial gainful activity. Make work is work involving minimal or insignificant duties. It makes little or no demand on an individual and contributes little or nothing to the employer or the individual’s business (if self-employed).

**Significance of earnings.** An individual’s earnings amount during a period of alleged disability may establish that he is able to engage in substantial gainful activity. Substantial earnings generally do so; however, low or no earnings during a period of work activity do not establish an inability to engage in substantial gainful activity. The circumstances under which work is performed are considered.

If an individual must stop working after a short time (less than six months) because his impairment worsens or prevents him from working, his earnings will not necessarily demonstrate his ability to engage in substantial gainful activity.

If an individual works under special conditions (for example, in a sheltered workshop), only the earnings relating to his own efforts are considered. Subsidies based on financial need or other nonwork factors are not considered. The fact that a sheltered establishment operates at a deficit or receives charitable or governmental aid is not material.

**Impairment-related expenses.** The cost of certain impairment-related items and services (for example, attendant care services, medical devices and equipment, prostheses and similar items and services that are necessary to control the individual’s disabling condition) needed in order to work are deductible from earnings.

**2010 earnings thresholds.** Normally, an individual making more than $1,000 net of impairment-related expenses per month in 2011 is considered to be engaged in substantial gainful activity. This amount is increased to $1,640 per month for blind individuals. The monthly substantial gainful activity amount can be adjusted each year based on the national average wage.
An individual’s actual earnings as a nonblind, self-employed worker may be given less weight in determining that his ability to do substantial gainful activity than the extent of his activity in the business. This is so because earnings or losses from an individual’s business may be due to factors other than work activities. For example, business may have only a small profit or may operate at a loss, even if the individual’s work is enough to be considered substantial and gainful.

Medical and Other Evidence of Disability

The SSA needs evidence from an acceptable medical source to establish whether an individual has a medically determinable impairment. These sources are:

1. Licensed physicians (medical or osteopathic doctor).
2. Licensed or certified psychologists, including school psychologists or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing mental retardation, learning disabilities and borderline intellectual functioning only.
3. Licensed optometrists, for purposes of establishing visual disorders only (except, in the U.S. Virgin Islands, licensed optometrists, for the measurement of visual acuity and visual fields only).
4. Licensed podiatrists, for impairments of the foot, or foot and ankle only, depending on whether the state in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle.
5. Qualified speech-language pathologists, for purposes of establishing speech or language impairments only.

Medical reports should include:

1. Medical history.
2. Clinical findings (such as the results of physical or mental status examinations).
3. Laboratory findings (such as blood pressure results or x-rays).
4. Treatment prescribed with response.
5. Diagnosis.
6. Prognosis.
7. A statement from the acceptable medical source, based on the above elements, about what the individual can still do despite his impairment. **Exception:** This statement is not needed in blindness claims.

For an adult, the statement should describe his ability to do work-related functions, such as sitting, standing or moving about, lifting, carrying, handling objects, hearing or speaking, and, in cases of mental impairment, the medical source’s opinion about their ability to understand, to carry out and remember instructions and to respond appropriately to supervision, coworkers and work pressures in a work setting.
In addition to medical evidence from acceptable medical sources, the SSA may use evidence from other sources to show the severity of an individual’s impairment and how it affects his ability to work. Other sources include nurse practitioners, physician assistants, chiropractors and therapists, as well as nonmedical sources, such as the individual’s spouse, relatives, neighbors, friends, teachers, social workers, coaches and day-care providers.
SELF-STUDY QUIZ

Determine the best answer for each question below. Then check your answers with the correct answers in the following section.

21. In which of the following scenarios would the widow’s benefit rate equal 100% of the deceased worker’s primary insurance amount?
   a. Sam is entitled to widow’s insurance benefits. Her deceased husband Max began receiving benefits in April and reached full retirement age in May.
   b. Sam chooses to receive reduced benefit payments for two months before she reaches her full retirement age.
   c. Sam is caring for her deceased husband’s 16-year-old son, Matt.

22. An individual is entitled to widow(er)’s benefits even if he/she was not married to the deceased worker for at least nine months just prior to the worker’s death, if the widow(er) was married to the insured worker at the time of his death and:
   a. The insured worker’s death was self-inflicted (suicide).
   b. The insured worker’s death occurred in the line of duty as a member of a law enforcement agency.
   c. The widow(er) was previously married to the insured worker, but the marriage ended after 12 months.

23. Which of the following is true regarding surviving child’s benefits?
   a. Sam, a disabled child, has been receiving benefits. His disability ended in April; therefore, his disabled child’s benefits terminated in May.
   b. Nick’s deceased father’s PIA was $600 per month. Nick’s monthly benefit amount is $450.
   c. Mary, who was entitled to child’s insurance benefits on her deceased mother’s earnings record, must file an application for benefits.
   d. Megan, an 18-year-old child, is eligible for child’s insurance benefits.

24. A surviving child’s benefits may not be payable for some months in which of the following circumstances?
   a. The child is an alien who is outside the U.S. for more than 12 calendar months in a row.
   b. Deportation of the insured parent is being considered, and the child is an alien who is outside the U.S.
   c. The child does not have a Social Security number and will not apply for one.
   d. The child works outside the U.S. for more than 40 hours per month.
25. Which of the following accurately describes a type of disability protection provided by Social Security?

a. Cash benefits for a disabled child are payable beginning at age 16.

b. Hospital and supplementary medical insurance protection for individuals whose disability did not end before December 31, 1979.

c. Hospital and supplementary medical insurance protection for individuals under age 65 who have been entitled to disability benefits as a disabled worker, widow(er) or adult child for at least 12 months.

d. Prescription drug benefit for individuals entitled to hospital insurance.

26. Which of the following circumstances does not demonstrate Bill’s ability to do substantial gainful activity and, therefore, would not prevent him from being considered disabled?

a. Bill has enjoyed significant earnings during a period in which he has claimed disability.

b. Bill has performed minimal duties for his employer or his own business.

c. Bill has performed substantial gainful activity but is classified as statutorily blind.

d. Bill was forced to cease working after nine months because his disability was worsening.
SELF-STUDY ANSWERS

This section provides the correct answers to the self-study quiz. If you answered a question incorrectly, reread the appropriate material in this lesson. (References are in parentheses.)

21. In which of the following scenarios would the widow’s benefit rate equal 100% of the deceased worker’s primary insurance amount? (Page 65)

   a. Sam is entitled to widow’s insurance benefits. Her deceased husband Max began receiving benefits in April and reached full retirement age in May. [This answer is incorrect. If the worker or spouse began receiving insurance benefits prior to reaching FRA, the widow’s insurance benefit rate is less than 100% of the worker’s PIA.]

   b. Sam chooses to receive reduced benefit payments for two months before she reaches her full retirement age. [This answer is incorrect. Since Sam has chosen to receive a reduced benefit rate before reaching full retirement age, she will continue to receive the reduced rate for as long as she is entitled to widow’s benefits.]

   c. Sam is caring for her deceased husband’s 16-year-old son, Matt. [This answer is correct. Since Matt is over age 16, Sam receives 100% of her husband’s PIA. If Matt were under age 16 or disabled or entitled to child’s insurance benefits, Sam’s retirement benefit would be reduced.]

22. An individual is entitled to widow(er)’s benefits even if he or she was not married to the deceased worker for at least nine months just prior to the worker’s death, if the widow(er) was married to the insured worker at the time of his death and: (Page 67)

   a. The insured worker’s death was self-inflicted (suicide). [This answer is incorrect. An individual is entitled to widow(er)’s benefits in cases where he/she was not married to the deceased worker for a period of at least nine months just prior to the worker’s death if the widow(er) was married to the insured worker at the time of his death and the insured worker’s death was accidental; that is, the insured worker (1) received bodily injuries through violent, external and accidental means; (2) the insured worker died within three months after the day that the injuries were received; and (3) the worker’s death was a direct result of the bodily injuries, independent of all other causes.]

   b. The insured worker’s death occurred in the line of duty as a member of a law enforcement agency. [This answer is incorrect. In order for an individual to be entitled to widow(er)’s benefits even if not married to the deceased worker for at least nine months just prior to the worker’s death, the insured worker’s death must have occurred in the line of duty while he/she was member of a uniformed service serving on active duty, and the widow(er) was married to the insured worker at the time of his death.]

   c. The widow(er) was previously married to the insured worker, but the marriage ended after 12 months. [This answer is correct. If the widow(er) was married to the deceased worker at the time of the insured worker’s death and they were previously married and divorced, as long as they were married longer than nine months, the exception to the nine-month duration of marriage requirement applies.]
23. Which of the following is true regarding surviving child’s benefits? (Page 69)

a. Sam, a disabled child, has been receiving benefits. His disability ended in April; therefore, his disabled child’s benefits terminated in May. [This answer is incorrect. His benefits would have terminated in June, because a disabled child’s benefits terminate effective with the second month following the month in which he is no longer under a disability.]

b. Nick’s deceased father’s PIA was $600 per month. Nick’s monthly benefit amount is $450. [This answer is correct. The surviving child’s benefit rate is 75% of the deceased parent’s PIA, $600 × .75 = $450.]

c. Mary, who was entitled to child’s insurance benefits on her deceased mother’s earnings record, must file an application for benefits. [This answer is incorrect. An application is not required if the child was entitled to child’s insurance benefits on the deceased parent’s earnings record for the month before the month in which the parent died.]

d. Megan, an 18-year-old child, is eligible for child’s insurance benefits. [This answer is incorrect. Megan may be eligible for child’s insurance benefits if she is a full-time student or if she is under a disability.]

24. A surviving child’s benefits may not be payable for some months in which of the following circumstances? (Page 70)

a. The child is an alien who is outside the U.S. for more than 12 calendar months in a row. [This answer is incorrect. A surviving child’s benefits may not be payable for some months if the child is an alien who is outside the U.S. for more than six calendar months in a row.]

b. Deportation of the insured parent is being considered, and the child is an alien who is outside the U.S. [This answer is incorrect. In order for a surviving child’s benefits to be nonpayable for some months, the insured parent must have already been deported.]

c. The child does not have a Social Security number and will not apply for one. [This answer is correct. The child’s insurance benefit may not be payable for some months in cases where the child does not have a Social Security number, and the child or his/her parent, guardian or individual acting on the child’s behalf refuses to apply for one.]

d. The child works outside the U.S. for more than 40 hours per month. [This answer is incorrect. The child must work outside the U.S. for more than 45 hours per month in order for the child’s insurance benefit to be nonpayable for some months.]
25. Which of the following accurately describes a type of disability protection provided by Social Security? (Pages 72)

a. Cash benefits for a disabled child are payable beginning at age 16. [This answer is incorrect. Social Security provides disability protection in the form of cash benefits for a disabled child that are payable beginning at age 18, not at age 16.]

b. Hospital and supplementary medical insurance protection for individuals whose disability did not end before December 31, 1979. [This answer is incorrect. Social Security provides hospital and supplementary medical insurance protection for individuals whose disability did not end before December 1, 1980.]

c. Hospital and supplementary medical insurance protection for individuals under age 65 who have been entitled to disability benefits as a disabled worker, widow(er) or adult child for at least 12 months. [This answer is incorrect. Social Security provides hospital and supplementary medical insurance protection for individuals under age 65 who have been entitled to disability benefits as a disabled worker, widow(er) or adult child for at least 24 months.]

d. Prescription drug benefit for individuals entitled to hospital insurance. [This answer is correct. Social Security provides disability protection by means of prescription drug benefit for individuals entitled to hospital insurance or enrolled in supplementary medical insurance.]

26. Which of the following circumstances does not demonstrate Bill’s ability to do substantial gainful activity and, therefore, would not prevent him from being considered disabled? (Page 74)

a. Bill has enjoyed significant earnings during a period in which he has claimed disability. [This answer is incorrect. If Bill experienced significant or substantial earnings during a period when he was claiming disability, such earnings may indicate his ability to engage in substantial gainful activity and prevent him from being considered disabled.]

b. Bill has performed minimal duties for his employer or his own business. [This answer is correct. Bill’s performance of minimal or insignificant duties for his employer, or his own business if he is self-employed, is considered “make work” which does not demonstrate his ability to perform substantial gainful activity. Therefore, he may still be classified as disabled.]

c. Bill has performed substantial gainful activity but is classified as statutorily blind. [This answer is incorrect. Bill’s performance of substantial gainful activity does not prevent a finding of blindness and, therefore, qualify Bill for disability so long as he is classified as statutorily blind. His earnings are considered under provisions covering income and resources.]

d. Bill was forced to cease working after nine months because his disability was worsening. [This answer is incorrect. If Bill had been forced to cease working after a period of time less than six months, his earnings would not necessarily have demonstrated his ability to engage in substantial gainful activity. However, since Bill had been working for nine months prior to having to cease working due to deterioration of his condition, his earnings may have demonstrated his ability to engage in substantial gainful activity and disqualify him as being disabled.]
EXAMINATION FOR CPE CREDIT

Lesson 5

Determine the best answer for each question below, then log onto our Online Grading System at cl.thomsonreuters.com/ogs to record your answers.

21. John was employed by Johnson Electric Products Co. when he died. John is survived by his wife, Susan, his son, Adam, his mother and father, Jane and Robert, and his brother and sister, Jerry and Alice. Which of the following surviving relatives is not eligible to receive John’s survivor’s benefits in the form of cash payments?

a. Alice.
b. Susan.
c. Jane.
d. Adam.

22. Which of the following individuals is considered a surviving divorced spouse and is entitled to surviving divorced spouse’s insurance benefits on the deceased worker's Social Security record?

a. Sheri was married to Joe, the deceased worker, from March 10, 1991, until April 23, 1998, when her divorce from him became final.
b. Thomas married Candice, the deceased worker, on April 15, 1992. Their divorce was final on January 29, 2002.
c. Patricia was married to Claude, the deceased worker, from June 1, 1998, until May 10, 2009, when their divorce became final.

23. Which individual described below is entitled to benefits on their prior deceased spouse's Social Security earnings record?

a. Gary becomes disabled and subsequently remarries at age 45.
b. Randy remarries at age 40 and subsequently becomes disabled.
c. Jack becomes disabled and subsequently remarries at age 53.
d. Rubin remarries at age 55 and subsequently becomes disabled.
24. Which of the insured worker’s dependents is eligible for surviving child’s benefits?
   a. Son-in-law.
   b. Step-grandchild.
   c. Niece or nephew.
   d. Married daughter.

25. Under Title II, which of the following individuals is entitled to disability cash benefits?
   a. Jim committed an armed robbery (a felony) on July 14, 1979, and his impairment is related to his commission of the felony.
   b. Andy was at fault in an automobile accident in which the other driver was killed (involuntary manslaughter, a felony) on March 12, 1981, and his impairment is related to his commission of the felony.
   c. Earl committed a murder (a felony) on November 30, 1980, and his impairment is related to his commission of the felony.
   d. Do not select this answer choice.

26. Which of the following medical professionals cannot provide evidence considered acceptable to the Social Security Administration of an individual’s medically determinable impairment?
   a. Robert Drake, M.D.
   b. Janice Blakely, licensed dentist.
   c. Andrew Gowan, licensed podiatrist.
   d. Paula Green, qualified speech pathologist.
Lesson 6: Medicare

Learning Objectives

Completion of this lesson will enable you to:

- Identify the various parts of Medicare and explain the eligibility requirements and coverage options.

Medicare is health insurance for individuals age 65 and older, under age 65 with certain disabilities and any age with end-stage renal disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Eligibility

Generally, individuals are eligible for Medicare if they or their spouse worked for at least 10 years in Medicare-covered employment and are 65 years or older and a citizen or permanent resident of the U.S. If an individual is not yet 65, he may also qualify for coverage if he has a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant).

Medicare Basics

Part A (Hospital Insurance)

Medicare Part A helps cover the insured’s inpatient care in hospitals (critical access hospitals and inpatient rehabilitation facilities), skilled nursing facilities after a hospital stay and Religious Nonmedical Health Care Institutions. Part A also helps cover hospice services and home health care services. Medicare doesn’t cover custodial or long-term care. An individual must meet certain conditions to receive these benefits.

Part A cost. Most individuals are automatically enrolled in Part A and do not have to pay a monthly premium if they or a spouse paid Medicare taxes while they were working.

If an individual (or his spouse) did not pay Medicare taxes while he worked, and that individual is age 65 or older, he may still be able to apply for Part A, but he will have to pay a premium. The total premium for 2011 is $450. Individuals having 30–39 quarters of Medicare covered employment can obtain the coverage for Part A for a premium of $248.

Part B (Medical Insurance)

Medicare Part B helps cover medically necessary services like doctors’ services, outpatient care and other medical services that Part A doesn’t cover. Part B is optional and helps pay for covered medical services and items when they are medically necessary.

Part B cost. Most individuals will pay the standard monthly Part B premium of $96.40 for 2011, but some people will pay a higher premium based on their income. If an individual is single (files an individual tax return) and his yearly modified AGI is more than $85,000, or if he is married (files a joint tax return) and it is more than $170,000, his monthly Medicare Part B premium may be higher than the standard premium. These amounts change each year.
Also, in some cases, an individual’s monthly premium amount may be higher if he did not sign up for Part B when he first became eligible. The cost of Part B may go up 10% for each 12-month period that an individual could have had Part B but did not sign up for it. He will have to pay this extra amount as long as he has Part B, except in special cases.

An individual can find out if he has Part A and/or Part B by looking at his Medicare card. An individual should keep this card safe. He will use this card to get his Medicare-covered services in Original Medicare.

### Part B Premiums

<table>
<thead>
<tr>
<th>Monthly Premium</th>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single</td>
</tr>
<tr>
<td>$ 96.40</td>
<td>$ 85,000 or less</td>
</tr>
<tr>
<td>161.50</td>
<td>85,001–107,000</td>
</tr>
<tr>
<td>230.70</td>
<td>107,001–160,000</td>
</tr>
<tr>
<td>299.90</td>
<td>160,001–214,000</td>
</tr>
<tr>
<td>369.10</td>
<td>Over $214,000</td>
</tr>
</tbody>
</table>

1. There may be a late-enrollment penalty.
2. If the SSA withholds the Part B premium; otherwise, $115.40.

### Medicare Plan Choices

Individuals can receive Medicare health coverage through Original Medicare, a Medicare advantage plan (such as an HMO or PPO) or another Medicare health plan. He can receive his prescription drug coverage from a Medicare prescription drug plan or a Medicare health plan that offers prescription drug coverage.

**Original Medicare** pays for many health care services and supplies, but it doesn’t cover all medical costs. To help cover extra health care costs, an individual may want to get a Medigap (Medicare Supplement Insurance) policy. See “Original Medicare” below. He may also want to join a Medicare prescription drug plan to help pay for his prescription drugs. He can choose one or both of these types of additional coverage.

**Medicare advantage plans** provide extra benefits and have lower out-of-pocket costs for some services than Original Medicare. However, an individual may be required see doctors that belong to the plan or go to certain hospitals to get services. If an individual joins a Medicare advantage plan, he does not need a Medigap policy.

### Original Medicare

Original Medicare is one of the Medicare health coverage choices. An individual will have Original Medicare unless he chooses to join a Medicare health plan. An individual can see any doctor or provider enrolled in Medicare and accepting new patients. No referrals are necessary.

In Original Medicare, if an individual has Medicare Part A and/or Part B, he gets all the Part A and/or Part B-covered services. He must pay a monthly Medicare Part B premium to receive the Part B-covered services. An individual may have to pay additional costs like a deductible, coinsurance or copayment for some Medicare-covered services.
In addition to Original Medicare, individuals can buy a Medicare prescription drug plan or a Medigap (Medicare Supplement Insurance) policy to help pay their health care costs.

Medigap policies are not available in all states for people with a disability or who have end-stage renal disease (ESRD).

**Medicare Advantage Plans**

An individual must have both Medicare Part A and Part B to join a Medicare advantage plan (such as an HMO or PPO). These plans are available in most areas of the country.

Individuals who join a Medicare advantage plan will receive at least all the Medicare Part A and Part B covered services listed in this lesson. Medicare advantage plans may offer extra coverage, such as vision, hearing, dental and/or health and wellness programs. Most include Medicare prescription drug coverage (usually for an extra cost). Some Medicare advantage plans have provider networks. This means an individual probably has to see doctors who belong to the plan or go to certain hospitals to receive covered services (other than for emergency or urgently needed care or medically necessary dialysis). An individual may need a referral to see specialists.

Individuals who join a Medicare advantage plan do not need a Medigap policy, and they cannot join a separate Medicare prescription drug plan.

**Other Ways to Pay Medicare Costs**

**Medigap**

Original Medicare pays for many health care services and supplies, but there are many costs it doesn't cover. To help cover health care costs, an individual may want to buy a Medigap (Medicare Supplement Insurance) policy. Medicare does not pay any of the costs for a Medigap policy.

A Medigap policy is health insurance sold by private insurance companies to fill gaps in Original Medicare coverage. Medigap policies help pay an individual’s share (coinsurance, copayments or deductibles) of the costs of Medicare-covered services, and some policies cover certain costs not covered by Original Medicare.

**Reduced Costs for Medicare Prescription Drug Coverage**

If an individual has limited income and resources, he may qualify for reduced prescription drug costs. If an individual qualifies, he will receive assistance paying for his drug plan’s monthly premium, yearly deductible and prescription drug copayments.

The amount of cost reduction is based on income and resources. For 2011, the resource limit is $12,640 for individuals and $25,260 for couples living together. 2011 income limits were not available at time of publication, but for 2010, income was limited to $16,245 for individuals ($21,855 for couples living together). In calculating resources, an individual’s savings and stocks are included in the calculation. The following are not counted in resources:

1. Principal residence.
2. Personal auto.
3. Personal possessions.
4. Burial plots and irrevocable burial contracts.

Beginning January 1, 2010, law changes made it easier for some individuals to qualify for reduced costs. Under the Medicare Improvements for Patients and Provider Act, life insurance policies will no longer be counted as a resource. In addition, help received regularly from someone to pay for household expenses such as food, mortgage, rent, heating fuel, gas, electricity, water and property taxes will not be included in income.

Medicare Prescription Drug Coverage

Medicare offers prescription drug coverage (Part D) for everyone with Medicare. To receive Medicare drug coverage, an individual must join a Medicare drug plan. Medicare drug plans are run by insurance companies and other private companies approved by Medicare. Each plan can vary in cost and drugs covered. Even if an individual does not take many prescription drugs now, he should still consider joining a Medicare drug plan.

If an individual joins a Medicare drug plan, he usually pays a separate monthly premium in addition to the Part B premium. There are two ways to get Medicare prescription drug coverage:

1. Join a Medicare prescription drug plan. These plans (sometimes called PDPs) add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans and Medicare.
2. Join a Medicare advantage plan (like an HMO or PPO) or another Medicare health plan that includes prescription drug coverage. An individual gets all of his Medicare coverage (Part A and Part B) and prescription drugs (Part D) through these plans. These plans are sometimes called MA-PDs.

Even if an individual waits to sign up for Medicare drug coverage, he will not have to pay a late-enrollment penalty if he has been covered under certain other types of prescription drug coverage, called creditable prescription drug coverage. An individual may not have to pay a late-enrollment penalty if he joins later and has creditable coverage through another source. This could include drug coverage from a former employer or union, TRICARE, the Department of Veterans Affairs or certain Medigap policies. An individual’s current prescription drug coverage is required to tell him each year whether the drug coverage he has is creditable. An individual should keep this annual notice, as he may need it if he decides to enroll in a Medicare drug plan later.

Deciding Whether or Not to Keep Medicare Part B

Individuals are automatically enrolled in Medicare Part B. They should look at the Medicare Part B effective date on the front of their Medicare card. If they do not want to keep Medicare Part B, they must notify Medicare before that date.

Medicare Part B Cost

The Part B premium is usually taken out of an individual’s monthly Social Security, railroad retirement or Office of Personnel Management payment. The premium is taken out when Medicare Part B coverage begins. If the payment is not deducted from the benefit, Medicare will bill the individual for the premium every three months.
Opting Out of Part B

Individuals who do not want to keep Medicare Part B must do the following:

- Check the box after “I don’t want Medical Insurance” on the back of the card form.
- Sign the back of the card.
- Send back the entire card form with the Medicare card in the enclosed envelope before the effective date on the front of the Medicare card.

Medicare will send them a new Medicare card showing that they only have Medicare Part A.

Keeping Medicare Part B

Keeping Medicare Part B is an individual’s choice. Except in special cases, individuals who choose not to keep Medicare Part B when they are first eligible will pay a higher monthly premium if they later decide they want it. Individuals who keep Medicare Part B will get all the Medicare Part B-covered services listed in the “Medicare Part B—Covered Services” table in the Appendix. If an individual does not keep Medicare Part B, Medicare will not pay for these services, including the “Welcome to Medicare” physical exam.

Medicare Part B may not yet be needed in the following situations:

- An individual is age 65 or older and that individual or his spouse (of any age) is working, and he is covered by an employer or union group health plan based on that current employment.
- An individual is under age 65 and disabled and that individual or any member of his family is working, and he is covered by an employer or union group health plan based on that current employment.

In these situations, an individual can wait to sign up for Medicare Part B. An individual can sign up any time while he is still covered by an employer or union group health plan based on current employment. An individual can also sign up for up to eight months after he loses his employer health coverage, or the employment ends, whichever is first. (This is called a special enrollment period.) Most individuals who sign up for Medicare Part B during a special enrollment period don’t pay higher premiums. An individual may also want to buy a Medigap policy during this period.

If an individual is still working and plans to keep his employer or union group health plan coverage, he should talk to his employer benefits administrator or his State Health Insurance Assistance Program (SHIP) to help him decide the best time to enroll in Medicare Part B.

Delaying Medicare Part B

If an individual does not take Medicare Part B when he first becomes eligible, he may have to wait until the general enrollment period (January 1–March 31 each year) to sign up. An individual’s Medicare Part B coverage would start July of that year. The cost of Medicare Part B will go up 10% for each full 12-month period an individual could have had Medicare Part B but did not take it, except in special cases. An individual may have to pay this late enrollment penalty as long as he has Medicare Part B.
Medicare Part B and TRICARE Coverage

Individuals with TRICARE coverage (for active-duty military or retirees and their families) must have Medicare Part B to keep TRICARE coverage. However, individuals who are active-duty service members or the spouse or dependent child of an active-duty service member may not have to get Medicare Part B right away. An individual can get Medicare Part B during a special enrollment period.

Deciding on Medicare Prescription Drug Coverage

The way an individual receives his Medicare health care affects how he can receive his Medicare prescription drug coverage. If an individual wants Medicare prescription drug coverage, he can receive one of the following plans:

- **Medicare prescription drug coverage with Original Medicare.** To get Medicare prescription drug coverage with Original Medicare, an individual will need to join a Medicare prescription drug plan. An individual must have Medicare Part A and/or Part B to join a Medicare prescription drug plan.

- **Medicare prescription drug coverage through a Medicare advantage plan (such as an HMO or PPO) or other Medicare health plan.** To receive Medicare drug coverage through a Medicare advantage plan, an individual must join a plan that offers prescription drug coverage. These plans are available in many areas. In most Medicare advantage plans, there generally are extra benefits and lower copayments than in Original Medicare. However, an individual may have to see doctors who belong to the plan or go to certain hospitals to get services. If an individual joins a Medicare advantage plan, he does not need a Medigap policy. An individual must have Medicare Part A and Part B to join most Medicare advantage plans.

If an individual does not join a Medicare drug plan when he is first eligible for Medicare, he may have to pay a late enrollment penalty to join a plan later. **Exception:** Individuals who qualify for reduced premiums are not charged a late enrollment penalty.

An individual's current or former employer or union may provide coverage for prescription drugs. It is crucial that an individual contact his employer or union benefits administrator before making a decision about his Medicare prescription drug coverage.

Options regarding prescription drug coverage:

- Original Medicare and a Medicare prescription drug plan.
- Original Medicare with a Medigap policy and a Medicare prescription drug plan.
- Medicare health plan with prescription drug coverage.
- Drug coverage from an employer or union, TRICARE, Veterans Affairs (VA), Federal Employees Health Benefits Program (FEHBP) or similar program.

Choosing a Medigap Policy

Once an individual is age 65 or older and is enrolled in Medicare Part B, he starts the six-month Medigap open enrollment period. During those six months, he can buy any Medigap policy he wants, even if he has a previous health condition. It is important to make this decision no later than six months after the date an individual’s Medicare Part B starts, and he
is age 65 or older. If an individual waits longer, he may pay more, or he may not be able to receive the Medigap policy he wants.

**Medicare Health Plans**

**Different Parts of Medicare**

The different parts of Medicare help cover specific services if an individual meets certain conditions:

**Medicare Part A (Hospital Insurance)**
- Helps cover inpatient care in hospitals; and
- Helps cover skilled nursing facility, hospice and home health care.

**Medicare Part B (Medical Insurance)**
- Helps cover doctors’ services and outpatient care; and
- Helps cover some preventive services to help maintain health and keep certain illnesses from getting worse.

**Medicare Part C (Medicare Advantage Plans)**
- Is a health coverage choice run by private companies approved by Medicare; and
- Includes Part A, Part B and usually other coverage including prescription drugs.

**Medicare Part D (Medicare Prescription Drug Coverage)**
- Helps cover the cost of prescription drugs.

**Medicare Coverage Choices**

With Medicare, an individual can choose how to get his health and prescription drug coverage. Following are brief descriptions of the coverage choices.

**Original Medicare**
- Run by the federal government.
- Provides Part A and Part B coverage.
- An individual can join a Medicare prescription drug plan to add drug coverage.
- An individual can buy a Medigap (Medicare Supplement Insurance) policy (sold by private insurance companies) to help fill the gaps in Part A and Part B coverage.

**Medicare Advantage Plans (such as an HMO or PPO)**
- Run by private companies approved by Medicare.
- Provides Part A and Part B coverage but can charge different amounts for certain services. May offer extra coverage and prescription drug coverage for an extra cost. Costs for items and services vary by plan.
- If an individual wants drug coverage, he must get it through the plan (in most cases).
- Does not necessitate a Medigap policy.
Other Medicare Health Plans

- Plans that aren’t Medicare advantage plans but are still part of Medicare.
- Include Medicare cost plans, Demonstration/Pilot Programs and Programs of All-inclusive Care for the Elderly (PACE).
- Some plans provide Part A and Part B coverage, and some also provide prescription drug coverage (Part D).

Medicare Services

Medicare covers certain medical services and supplies in hospitals, doctors’ offices and other health care settings. Services are either covered under Medicare Part A (Hospital Insurance) or Medicare Part B (Medical Insurance). If an individual has both Part A and Part B, that individual can get the full range of Medicare-covered services listed in this lesson, no matter what type of Medicare coverage is chosen.

Part A—Hospital Insurance

Coverage

Part A helps cover the following:

- Inpatient care in hospitals (includes critical access hospitals and inpatient rehabilitation facilities);
- Inpatient stays in a skilled nursing facility (not custodial or long-term care);
- Hospice care services;
- Home health care services; and
- Inpatient care in a facility that provides nonmedical, nonreligious health care items and services to individuals who need hospital or skilled nursing facility care but for whom that care wouldn’t be in agreement with their religious beliefs (called a Religious Nonmedical Health Care Institution).

Cost

An individual usually does not pay a monthly premium for Part A coverage if that individual or his spouse has at least 40 quarters of Medicare-covered employment.

If an individual is not eligible for premium-free Part A, he may be able to buy Part A if:

- He meets the citizenship or residency requirements and is age 65 or older; or
- He meets the citizenship or residency requirements, is under age 65, disabled and his premium-free Part A coverage ended because he returned to work.

The 2011 premium amount for individuals who buy Part A is $450 per month ($248 per month for individuals with 30-39 quarters of coverage). In most cases, individuals who choose to buy Part A, must also have Part B and pay monthly premiums for both. If an individual has limited income and resources, the state may help make payments for Part A and/or Part B.
Enrollment

**Automatic enrollment.** If an individual receives benefits from Social Security or the Railroad Retirement Board (RRB), that individual automatically receives Part A starting the first day of the month he turns age 65. Individuals under age 65 and disabled automatically receive Part A after receiving disability benefits from Social Security or certain disability benefits from the RRB for 24 months. An individual’s Medicare card will come in the mail three months before the individual’s 65th birthday or 25th month of disability.

Individuals who have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig’s disease), will automatically receive Part A the month that the disability benefits begin.

**Manual enrollment.** Individuals who aren’t receiving Social Security or RRB benefits (for instance, because they are still working) will need to sign up for Part A, even if they are eligible for premium-free Part A. They should contact Social Security three months before turning age 65. Individuals who worked for a railroad must contact the RRB to sign up.

If an individual has end-stage renal disease (ESRD), he can sign up for Part A by visiting the local Social Security office or by calling Social Security.

**When to buy.** If an individual is not eligible for premium-free Part A, he can buy it during the following times:

- **Initial Enrollment Period.** When the individual first becomes eligible for Medicare (three months before he turns age 65 to three months after the month he turns age 65).
- **General Enrollment Period.** Between January 1–March 31 each year.
- **Special Enrollment Period.** If an individual or his spouse (or family member, if the individual is disabled) is working and has group health plan coverage through the employer or union.
- **Special Enrollment Period for International Volunteers.** See page 94.

If an individual does not buy Part A when he is first eligible, the monthly premium may go up 10%, unless he is eligible for a special enrollment period.

**Part B—Medical Insurance**

Part B helps cover medically necessary services like doctors’ services, outpatient care and other medical services. Part B also covers some preventive services.

**Cost**

An individual pays the Part B premium each month. Most individuals will pay the standard premium amount, which is $96.40, in 2011. However, the monthly premium will be higher for certain higher-income individuals.

There is also a Part B deductible each year before Medicare starts to pay its share. In 2011, the deductible amount is $162.

**Late Enrollment Penalty**

If an individual does not sign up for Part B when first eligible, the monthly premium for Part B may go up 10% for each full 12-month period that the individual could have had Part B, but
didn’t sign up for it. If an individual delays taking Part B because the individual or the individual’s spouse (or a family member, if the individual is disabled) is working and has group health plan coverage based on current employment, that individual may not have to pay the higher premium.

**Enrollment Period**

If an individual receives benefits from Social Security or the RRB, he will automatically receive Part B starting the first day of the month he turns age 65. If that individual is under age 65 and disabled, he will automatically receive Part B after receiving disability benefits from Social Security or certain disability benefits from the RRB for 24 months. Medicare cards will arrive in the mail about three months before the individual’s 65th birthday or 25th month of disability. If Part B is not desired, follow the instructions that come with the card, and send the card back. If the card is kept, that individual keeps Part B and will pay Part B premiums.

If an individual has ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig’s disease), he automatically receives Part B the month the disability benefits begin.

If an individual has ESRD, he can sign up for Part B when signing up for Part A.

If an individual is not receiving Social Security or RRB benefits, and wants to receive Part B, that individual will need to sign up for Part B during the initial enrollment period (the period that begins three months before the month of his 65th birthday and ends three months after the month of his 65th birthday).

If an individual does not sign up for Part B when he first became eligible, he may be able to sign up during one of these times:

- **General enrollment period**—Between January 1–March 31 each year. Coverage will begin on July 1. The cost of Part B will go up 10% for each full 12-month period the individual could have had Part B but didn’t sign up for it, unless that individual qualifies for a special enrollment period (see below). He may have to pay this late enrollment penalty as long as he has Part B.

- **Special enrollment period.** An individual may wait to sign up for Part B because he or his spouse is working and has group health plan coverage based on that work, or if he is disabled and he or a family member is working and has group health plan coverage based on that work. The individual can sign up for Part B any time while he has group health plan coverage based on current employment or during the eight-month period that begins the month the employment ends, or the group health plan coverage ends, whichever happens first.

- **Special enrollment period for international volunteers.** If an individual waited to enroll in Part B because he had health insurance while volunteering in a foreign country, then he can sign up during the six-month period that begins the month after the individual is no longer volunteering outside the United States, the sponsoring organization is no longer tax exempt or the individual no longer has health coverage outside the U.S., whichever comes first.

Usually, an individual does not pay a late enrollment penalty if he signs up for Part B during a special enrollment period.
Call Social Security for more information about Medicare eligibility and to enroll in Part B. If an individual receives railroad retirement benefits, he should call the local RRB office. For general information about enrolling, he should visit www.medicare.gov and select, “Find Out if You Are Eligible for Medicare and When You Can Enroll.” Individuals can also receive free personalized health insurance counseling from the State Health Insurance Assistance Program (SHIP).

**Prescription Drug Coverage Basics**

Medicare prescription drug coverage (Part D) is coverage that adds to, or is included with, Medicare health care coverage. It helps individuals pay for both brand-name and generic drugs they need. Medicare drug plans are offered by insurance companies and other private companies approved by Medicare.

There are two ways to get Medicare prescription drug coverage:

- Medicare prescription drug plans (sometimes called PDPs) add prescription drug coverage to Original Medicare, some Medicare Private Fee-for-Service (PFFS) plans, some Medicare cost plans and Medicare medical savings account (MSA) plans.
- Medicare advantage plans (such as an HMO or PPO) or other Medicare health plans offer prescription drug coverage. An individual generally gets all of his Medicare Part A (Hospital Insurance), Part B (Medical Insurance) and Part D coverage through these plans. Medicare advantage plans with prescription drug coverage are sometimes called MA-PDs.

**The Affordable Care Act and Medicare Part D**

The Patient Protections and Affordable Care Act passed by Congress and signed by President Obama on March 23, 2010 contains some benefits for Medicare recipients, especially with regard to closing the Medicare prescription drug (Part D) coverage gap (also called the donut hole).

**The Coverage Gap**

Most Medicare drug plans have a coverage gap. This means that after an individual and his plan have spent a certain amount of money for covered drugs, he has to pay all costs out-of-pocket for his drugs (up to a limit). The Explanation of Benefits notice, which the drug plan mails to an individual each month when he fills a prescription, will tell him how much he has spent on covered drugs and whether he has entered the coverage gap.

**Medicare Drug Plans**

The term Medicare drug plan as used in this lesson means all plans that provide Medicare prescription drug coverage. An individual must choose and join a Medicare drug plan to get Medicare prescription drug coverage.

Everyone with Medicare has a decision to make about prescription drug coverage. Individuals who do not use many prescription drugs now should still consider joining a Medicare drug plan. This coverage may help lower prescription drug costs and help protect against higher costs in the future. If an individual is new to Medicare and currently has prescription drug coverage, he has new choices to consider. If an individual is not new to Medicare, he has the opportunity to
review options for drug coverage and join or switch Medicare drug plans between November 15 and December 31 of each year.

**Joining a Medicare prescription drug plan.** To join a Medicare prescription drug plan, individuals must be entitled to Medicare Part A and/or have Medicare Part B. To join a Medicare advantage plan or other Medicare health plan with prescription drug coverage, individuals must have Medicare Parts A and B. They must also live in the service area of the Medicare drug plan they want to join.

**Comparing plans.** Medicare drug plans vary in what prescription drugs they cover, how much an individual has to pay and which pharmacies he can use. All Medicare drug plans must provide at least a standard level of coverage set by Medicare. However, plans offer different combinations of coverage and cost sharing. Having a variety of plans to choose from gives an individual the chance to pick a plan that gives him the coverage he wants at the best price possible.

If an individual does not join a Medicare drug plan when he is first eligible, and that individual does not have drug coverage that is, on average, expected to pay at least as much as standard Medicare prescription drug coverage (called creditable prescription drug coverage), he may have to pay a late enrollment penalty if he joins later. The penalty is in addition to the individual’s premium each month for as long as that individual has a Medicare drug plan.

**How Part B coverage differs.** Part B provides limited prescription drug coverage. Part B covers certain drugs, such as certain injectable, cancer and immunosuppressive drugs. Individuals pay coinsurance, and the Part B deductible applies. Part B also covers the flu and pneumococcal vaccines. Generally, Medicare drug plans cover vaccines (for example, the shingles vaccine) that aren’t covered under Part B when the vaccine is needed to prevent illness.

Generally, self-administered drugs an individual gets in an outpatient setting (for example, an emergency room, observation unit, surgery center or pain clinic) are not covered by Medicare Parts A or B. An individual’s Medicare drug plan may cover these drugs under certain circumstances. That individual may need to pay out-of-pocket for these drugs and contact his plan provider to get back some of the cost. Individuals should call their plan provider for more information.

**Choosing Prescription Drug Coverage**

Individuals should take time to consider all of their choices for prescription drug coverage before making a decision. This may include looking at the prescription drug coverage they already have, like coverage from an employer or union, TRICARE, the Department of Veterans Affairs, the Indian Health Service or a Medigap (Medicare Supplement Insurance) policy. They should compare it to Medicare prescription drug coverage. The prescription drug coverage an individual already has may change as a result of Medicare prescription drug coverage, so it is important for individuals to consider all of their coverage options.

**Integration with other coverage.** Individuals who have (or are eligible for) other types of prescription coverage should read all the materials they receive from their insurer or plan provider. They should talk to their benefits administrator, insurer or plan provider before making any changes to their current coverage.
How Prescription Drug Coverage Works

Medicare drug plans vary in which drugs they cover, what an individual’s out-of-pocket costs will be and which pharmacies that individual can use. Comparing plans based on coverage, cost, convenience and quality can help an individual decide which plan meets his needs.

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

- **Cost.** Plans have different monthly premiums, and how much an individual pays for each prescription varies depending on which plan he chooses. Individuals with limited income and resources may qualify for reduced costs.

Paying for a Medicare Drug Plan Premium

In general, there are four ways an individual can pay his Medicare drug plan premiums. They can be:

- Deducted from a checking or savings account.
- Charged to a credit or debit card.
- Billed to the individual each month directly by the plan provider (some providers bill in advance for the next month’s coverage).
- Withheld from Social Security payments. Individuals should contact their plan provider (not Social Security) to ask for this payment option. If this option is chosen, the first two months of premiums will be combined.

**Example:** Ms. Brown chooses to have her premiums withheld from her Social Security checks. Her monthly drug plan premium is $25, and her coverage begins in January. Her first premium payment is collected in February for $50. It includes her premium for January and February. After February, only 1 month of premium payments ($25) will be withheld from her Social Security payment.

If an individual chooses to have the premium withheld from his Social Security payment, and that individual has another insurer or benefit that pays part of his drug plan premium [such as an employer health plan or a State Pharmacy Assistance Program (SPAP)], Social Security will withhold that individual’s entire monthly premium. The drug plan will need to give that individual a refund for the amount his employer health plan or SPAP paid.

Window for Joining, Switching or Dropping a Plan

Individuals can join, switch or drop a Medicare drug plan at these times:

- **When they first become eligible for Medicare.** They can join three months before they turn age 65 to three months after the month they turn age 65.

- **During the three months before to three months after their 25th month of disability.** This applies to individuals who get Medicare coverage due to their disability.
• Between November 15–December 31 each year. Coverage will begin on January 1 of the following year as long as the plan receives the request for enrollment by December 31.

• At any time if they qualify for reduced costs. This includes individuals who have Medicare and Medicaid, belong to a Medicare savings program, get Supplemental Security Income (SSI) benefits and those who apply and qualify.

In certain limited circumstances, an individual may be able to switch to another Medicare drug plan. For example, an individual may be able to switch at other times if he permanently moves out of his drug plan’s service area; loses creditable prescription drug coverage or if he enters, lives in or leaves a nursing home.
SELF-STUDY QUIZ

Determine the best answer for each question below. Then check your answers with the correct answers in the following section.

27. Charles Dutton and his wife Sarah have been married for 50 years. Sarah has been diagnosed with lung cancer and will need hospice care. Which of the following plans cover hospice services?
   a. Medicare Part A.
   b. Medicare Part B.
   c. Medicare Part D.
   d. Medigap.

28. What is the 2011 monthly Medicare Part B premium for an individual filing single with an annual income of $159,000, and a late-enrollment penalty?
   a. $96.40.
   b. $161.50.
   c. $230.70.
   d. $253.77.

29. Which of the following people may qualify for assistance with their prescription drug costs?
   a. Steve and his wife Linda, earned $15,000 and $7,000 respectively in 2010. They don’t have any savings but they do own their home.
   b. Sammie’s income for 2010 was $11,500. Her car is worth $5,000 and her wedding ring is worth $3,000.
   c. Joe has $13,500 in his savings account but he earned only $7,500 in 2010. He also owns a rare coin collection valued at $20,000.
   d. Leigh and Dave own their home, valued at $125,000. They have 8,000 in savings and own 200 shares of Izzy Corp., valued at $100 per share. Dave earned $21,000 in 2010 as a teacher’s assistant.
30. Which of the following statements regarding Medicare Part B is most accurate?

a. Individuals must enroll in Medicare Part B.

b. Most individuals who sign up for Medicare Part B during a special enrollment period will not pay higher premiums.

c. The enrollment period for Medicare Part B is January 1 through April 31 of each year.

d. Medicare Part B does not cover prescription drugs.
SELF-STUDY ANSWERS

This section provides the correct answers to the self-study quiz. If you answered a question incorrectly, reread the appropriate material in this lesson. (References are in parentheses.)

27. Charles Dutton and his wife Sarah have been married for 50 years. Sarah has been diagnosed with lung cancer and will need hospice care. Which of the following plans cover hospice services? (Page 85)

a. Medicare Part A. [This answer is correct. Medicare Part A assists the insured’s inpatient care in hospitals, skilled nursing facilities after a hospital stay, and Religious Nonmedical Health Care institutions. Part A also helps cover hospice services and home health care services.]

b. Medicare Part B. [This answer is incorrect. Medicare Part B helps cover medically necessary services such as doctors’ services, outpatient care and other medical services that Part A does not cover.]

c. Medicare Part D. [This answer is incorrect. Prescription drugs are covered by Medicare Part D. Medicare offers prescription drug coverage (Part D) for everyone with Medicare.]

d. Medigap. [This answer is incorrect. A Medigap policy is health insurance sold by private insurance companies to fill gaps in Original Medicare coverage. Medigap policies help pay an individual’s share of the costs of Medicare-covered services, and some policies covers certain costs not covered by Original Medicare.]

28. What is the 2011 monthly Medicare Part B premium for an individual filing single with an annual income of $159,000 and a late enrollment penalty? (Page 86)

a. $96.40. [This answer is incorrect. This is the amount an individual will pay if filing single with an annual income of $85,000 or less with no enrollment penalty.]

b. $161.50. [This answer is incorrect. This is the amount an individual will pay if filing single with an annual income of $85,001–$107,000 with no enrollment penalty.]

c. $230.70. [This answer is incorrect. If an individual is filing single with an annual income of $107,000–$160,000 and no enrollment penalty, the premium is $230.70.]

d. $253.77. [This answer is correct. This is the amount an individual will pay if filing single with an annual income of $107,000–$160,000 and a 10% enrollment penalty.]
29. Which of the following people may qualify for assistance with their prescription drug costs? (Pages 87-88)

a. Steve and his wife Linda, earned $15,000 and $7,000 respectively in 2010. They don’t have any savings but they do own their home. [This answer is incorrect. Steve and Linda’s combined income of $22,000 is over the limit of $21,855 for couples living together. A principal residence is not considered when valuing resources.]

b. Sammie’s income for 2010 was $11,500. Her car is worth $5,000 and her wedding ring is worth $3,000. [This answer is correct. Sammie may qualify for assistance because her income for 2010 was below the limit of $16,265. The value of her car and wedding ring are not counted when assessing resources.]

c. Joe has $13,500 in his savings account but he earned only $7,500 in 2010. He also owns a rare coin collection valued at $20,000. [This answer is incorrect. Although Joe’s income is under the limit of $16,265, he doesn’t qualify for assistance because his savings of $13,500 exceed the resource limit for 2010 of $12,640.]

d. Leigh and Dave own their home, valued at $125,000. They have 8,000 in savings and own 200 shares of Izzy Corp., valued at $100 per share. Dave earned $21,000 in 2010 as a teacher’s assistant. [This answer is incorrect. Although their income is below the limit of $21,885 for couples living together, their savings and stock exceed the 2010 resource limit of $25,010. Their home is not counted as a resource.]

30. Which of the following statements regarding Medicare Part B is most accurate? (Page 89)

a. Individuals must enroll in Medicare Part B. [This answer is incorrect. Individuals are automatically enrolled in Medicare Part B. If an individual does not want to keep Medicare Part B coverage, he/she can check the box after “I don’t want Medical Insurance” on the back of the card form, sign the back of the card, and return the entire card form with the Medicare card before the effective date on the front of the Medicare card.]

b. Most individuals who sign up for Medicare Part B during a special enrollment period will not pay higher premiums. [This answer is correct. The late enrollment penalty, which results in higher monthly premiums, doesn’t apply if an individual signs up during the general enrollment period or a special enrollment period.]

c. The enrollment period for Medicare Part B is January 1 through April 31 of each year. [This answer is incorrect. If an individual does not enroll in Medicare Part B when he/she first becomes eligible, he/she may have to wait until the general enrollment period, which is January 1 through March 31 of each year.]

d. Medicare Part B does not cover prescription drugs. [This answer is incorrect. Part B provides limited prescription drugs such as certain injectables, and cancer and immunosuppressive drugs.]
EXAMINATION FOR CPE CREDIT

Lesson 6

Determine the best answer for each question below, then log onto our Online Grading System at cl.thomsonreuters.com/ogs to record your answers.

27. Natalie wants to enroll in a Medicare Advantage Plan. In which of the following plans must Natalie be enrolled to qualify for the Medicare Advantage Plan?
   a. Medicare Part A.
   b. Medicare Part B.
   c. Medicare Parts A and B.
   d. Medigap.

28. Which of the following is correct regarding Medicare Part B?
   a. If Mack’s employment was terminated on January 1, 2011, he has until August 31, 2011 to sign up for Medicare Part B coverage.
   b. If an individual didn’t take Medicare Part B when first eligible, the premiums may increase by 12%.
   c. Bob, age 65, may not need Medicare Part B because his wife is working and he is covered by her employer’s health plan.
   d. The premium payments can be charged to a credit or debit card.

29. When is an individual eligible for Medigap?
   a. Age 65 or older and enrolled in Medicare Part B.
   b. Age 65 or older and enrolled in Medicare Part A.
   c. Age 65 or older and enrolled in Medicare Parts A and B.
   d. Age 61 years and nine months and enrolled in Medicare Part B.

30. Which of the following statements regarding prescription drug coverage is most accurate?
   a. Individuals must be enrolled in Medicare Parts A and B to be eligible for a Medicare prescription drug plan.
   b. Medicare drug plans only cover generic drugs.
   c. Individuals must be enrolled in Medicare Parts A and B to be eligible for drug coverage with Original Medicare.
   d. Individuals can pay for Medicare drug plans by having the premiums deducted from a checking or savings account.
Glossary

Applicable Law – The law applied by the courts of the state where the insured worker was domiciled when filing for benefits or the District of Columbia if the insured worker was not domiciled in any state when filing for benefits.

Coinsurance – An amount an individual may be required to pay as his share of the cost for services after paying any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment – An amount an individual may be required to pay as his share of the cost for a medical service or supply, like a doctor’s visit or prescription. A copayment is usually a set amount, rather than a percentage.

Coverage Determination – The first decision made by a Medicare drug plan (not the pharmacy) about an individual’s drug benefits, including whether a particular drug is covered, whether the individual has met all the requirements for getting a requested drug, how much an individual is required to pay for a drug and whether to make an exception to a plan rule when an individual requests it. If the drug plan does not give an individual a prompt decision, and he can show that the delay would affect his health, the plan’s failure to act is considered to be a coverage determination. If an individual disagrees with the coverage determination, the next step is an appeal.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Deductible – The amount an individual must pay for health care or prescriptions, before Original Medicare, the prescription drug plan or other insurance begins to pay.

Drug List – A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. This list is also called a formulary.

Exception – A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan’s decision to cover a drug that’s not on its formulary or to waive a coverage rule. A tiering exception is a drug plan’s decision to charge a lower amount for a drug that is on its nonpreferred drug tier. Individuals must request an exception, and their prescriber must send a supporting statement explaining the medical reason for the exception.

Institution – A facility that provides short-term or long-term care, such as a nursing home, skilled nursing facility (SNF) or rehabilitation hospital. Private residences, such as an assisted living facility or group home, are not considered institutions.

Make Work – Work involving minimal or insignificant duties. It makes little or no demand on an individual and contributes little or nothing to the employer or the individual’s business (if self-employed).
Medicaid – A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if an individual qualifies for both Medicare and Medicaid.

Medically Necessary – Services or supplies that are needed for the diagnosis or treatment of a medical condition and meet accepted standards of medical practice.

Medicare Advantage Plan (Part C) – A type of Medicare health plan offered by a private company that contracts with Medicare to provide individuals with all their Medicare Parts A and B benefits. Medicare advantage plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service plans, Special Needs Plans and Medicare Medical Savings Account plans. If an individual is enrolled in a Medicare advantage plan, Medicare services are covered through the plan and are not paid for under Original Medicare. Most Medicare advantage plans offer prescription drug coverage.

Medicare Cost Plan – A type of Medicare health plan available in some areas. In a Medicare cost plan, when individuals get services outside of the plan’s network without a referral, their Medicare-covered services will be paid for under Original Medicare (the cost plan pays for emergency services or urgently-needed services).

Medicare Health Maintenance Organization (HMO) – A type of Medicare advantage plan (Part C) available in some areas of the country. In most HMOs, an individual can only go to doctors, specialists or hospitals on the plan’s list, except in an emergency. Most HMOs also require an individual to get a referral from his primary care physician.

Medicare Medical Savings Account (MSA) Plan – MSA plans combine a high deductible Medicare advantage plan and a bank account. The plan deposits money from Medicare into the account. An individual can use the money in this account to pay for health care costs, but only Medicare-covered expenses count toward an individual’s deductible. The amount deposited is usually less than the deductible amount so an individual generally will have to pay out-of-pocket before coverage begins.

Medicare Preferred Provider Organization (PPO) Plan – A type of Medicare advantage plan available in some areas of the country in which individuals pay less if they use doctors, hospitals and other health care providers that belong to the plan’s network. They can use doctors, hospitals and providers outside of the network for an additional cost.

Medicare Prescription Drug Plan (Part D) – A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare cost plans, some Medicare Private-Fee-for-Service Plans, and Medicare medical savings account plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare advantage plans may also offer prescription drug coverage that follows the same rules as Medicare prescription drug plans.

Medicare Private Fee-for-Service (PFFS) Plan – A type of Medicare advantage plan in which individuals can generally go to any doctor or hospital they could go to if they had Original Medicare, if the doctor or hospital agrees to treat them. The plan determines how much it will pay doctors and hospitals, and how much individuals must pay when they get care. A PFFS plan is very different than Original Medicare, and individuals must follow the plan rules carefully when going for health care services. When they are in a PFFS plan, they may pay more, or less, for Medicare-covered benefits than in Original Medicare.
Medigap Policy – Medicare Supplement Insurance sold by private insurance companies to fill gaps in Original Medicare coverage. Some Medigap policies sold before 2006, have prescription drug coverage. Policies sold after 2005 don’t have prescription drug coverage.

Original Medicare – Original Medicare is the fee-for-service plan under which the government pays health care providers directly for covered individuals’ Part A and/or Part B benefits.

Penalty – An amount added to the monthly premium for Medicare Part B or a Medicare drug plan (Part D) if individuals do not join Medicare when they are first eligible. They pay this higher amount as long as they have Medicare. There are some exceptions.

Premium – The periodic payment to Medicare, an insurance company or a health care plan for health or prescription drug coverage.

State Health Insurance Assistance Program (SHIP) – A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Pharmacy Assistance Program (SPAP) – A state program that provides help paying for drug coverage based on financial need, age or medical condition.
Appendix
### Worker Status—Twenty Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Is the worker required to follow instructions?</td>
<td>If the worker must follow instructions about when, where and how to work, he is ordinarily considered an employee. Instructions on how to do the job can be provided verbally or in written format (for example, manuals and written procedures). Even if the employer does not give the worker specific instructions, the worker is still an employee, provided the business has the right to instruct that worker.</td>
</tr>
<tr>
<td>2) Is the worker trained on how to do the job?</td>
<td>If the worker is trained by an experienced employee, a factor of control exists. The training shows that the employer has the right to require the worker to do the job in a particular way. This is especially true if training is provided periodically or frequently. On the other hand, independent contractors usually do their jobs using their own approach. Also, they are not trained by purchasers of their services.</td>
</tr>
<tr>
<td>3) Are workers services integrated in the business?</td>
<td>If the worker’s services are integrated into the business operations, a factor of control generally exists. Integration occurs when the services performed merge with the scope and function of the business. If the job the worker does is critical to the success of the business he works for, the worker is subject to a certain amount of control by the business owner.</td>
</tr>
<tr>
<td>4) Must the worker personally perform the work functions?</td>
<td>If the worker must personally do the job without the use of a substitute, a factor of control exists. This demonstrates that the employer has control over who does the job, how the job gets done and the results. On the other hand, if the worker has the right to hire a substitute without the employer’s knowledge, a lack of control may exist.</td>
</tr>
<tr>
<td>5) Who hires, supervises and pays assistants?</td>
<td>If the employer hires, supervises and pays assistants, then generally, the employer has control over all workers on the job. This can still be true when another worker hires, supervises and pays other workers at the direction of the employer. As long as the worker is acting as an employee in the capacity of a supervisor or a representative of the employer, control over workers on the job still exists. On the other hand, a worker that hires, supervises and pays other workers under a contract in which they are to provide the materials and labor would be considered an independent contractor.</td>
</tr>
</tbody>
</table>
| 6) Is the relationship with the employer an ongoing work relationship? | If the working relationship continues between the worker and the business they work for, a factor of control generally exists. This relationship tends to indicate an employer-employee relationship. If the worker is asked to work frequently on call or when work is made available, a continuing working relationship exists. This is true even under the following conditions:  
  • Services are requested at irregular intervals,  
  • Services are performed on a part-time basis,  
  • Services are obtained on a seasonal basis, or  
  • Services are for a short period of time. |
| 7) Does the worker have set hours at work? | If the employer has established a fixed work schedule for the worker, a factor of control exists. Normally, the ability to set working hours by the worker is the right of an independent contractor. In some cases, fixed hours may not be practical because of the nature of the position, however as long as the worker is required to work at certain times, an element of control still exists. |
| 8) Does the worker work full time at the business? | If the worker works full-time for the employer, a factor of control exists. Since the employer has control over the amount of time spent working, the worker is restricted from doing other gainful work. On the other hand, an independent contractor can choose for whom to work and when to work.  
  • Full-time does not necessarily mean an eight-hour work day or a five-day work week. The meaning of full-time may vary by the nature of the job, the customs where the employment takes place and intentions of both the worker and the employer.  
  • Although the worker does not have a formal agreement, full-time services may be required. For example, some workers are not contractually permitted to work for anyone else. Another example is a worker who has to meet a production minimum. This production minimum may require that the worker devote all working hours to the business. In the previous examples, the workers are considered full-time employees. |
<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9) <strong>Does the worker work on business premises?</strong></td>
<td>If the worker works at the employer’s place of business, it is implied that the employer has control. This is especially true if the type of work the worker does could be done elsewhere. Working at the employer’s place of business places the worker under the employer’s direction and supervision. The fact that a worker does not work on the employer’s premises does not necessarily mean that the worker is not an employee. Some occupations require services to be performed off premises. For example, employees of construction contractors must work off premises to perform their job duties. Further, with the advent of online commuting, it is common for employees to work out of their homes or at other locations. This is especially true in the computer consulting and sales professions.</td>
</tr>
<tr>
<td>10) <strong>Does the worker perform his job duties in the order or sequence set by the employer?</strong></td>
<td>If the worker carries out job duties in the order set by the employer, a factor of control exists. In this circumstance, the worker is not free to follow his own pattern of work. Instead, he must follow the established routines and schedules of his employer. Even if the employer does not set the order of the job tasks, he only needs the right to do so for control to exist.</td>
</tr>
<tr>
<td>11) <strong>Does the worker submit oral or written action reports to the employer?</strong></td>
<td>If the worker submits oral or written reports, a factor of control exists. The submission of reports, such as time sheets, shows that the worker is required to account for his actions.</td>
</tr>
<tr>
<td>12) <strong>Is the worker paid at specified intervals?</strong></td>
<td>If the worker is paid at regular intervals, a factor of control exists. In addition, if the worker is guaranteed a minimum salary, or if he is compensated through a drawing account (provided that they are not required to repay earnings in excess of the approved draw), an employer-employee relationship tends to exist. If the worker is paid by commission or on a job basis, he is probably an independent contractor. Payment by the job includes a lump sum. This lump sum is normally computed by the number of hours worked against a fixed rate per hour. The lump sum payment may be broken out into weekly or monthly installments if this method of payment is convenient for a particular job.</td>
</tr>
<tr>
<td>13) <strong>Does the employer pay the worker’s business and traveling expenses?</strong></td>
<td>If the employer pays the worker’s business and traveling expenses, a factor of control exists. On the other hand, a lack of control may exist if worker is paid on a job basis and is responsible for his own business and traveling expenses.</td>
</tr>
<tr>
<td>14) <strong>Is the worker provided with tools, materials, etc. to do the job?</strong></td>
<td>If the employer furnishes the various materials needed to do the job, a factor of control exists. On the other hand, if the worker furnishes his own tools, materials and equipment, a lack of control may exist unless it is common for employees in the field to use their own hand tools.</td>
</tr>
<tr>
<td>15) <strong>Does the worker invest in the facilities that he uses to do his duties?</strong></td>
<td>Facilities generally include the equipment or premises necessary for work. If the employer provides all necessary facilities, the worker is generally considered an employee. On the other hand, workers who invest in the equipment and premises necessary for work, tend to be independent contractors. <strong>Note:</strong> The tools, instruments, clothing, etc. that the worker provides as a common practice in their particular field are not considered an investment in facilities.</td>
</tr>
<tr>
<td>16) <strong>Does the worker have the opportunity for profit or loss?</strong></td>
<td>If the worker has an opportunity for profit or loss resulting from their services, they are generally considered an independent contractor. If the worker is not in such a position, they are likely to be considered an employee. Opportunity for profit or loss may be established by one or more circumstances. Examples of such circumstances if an individual: 1) Hires, direct and pays assistants; 2) Has his own office, equipment, materials or facilities for doing work; 3) Has continuing and recurring liabilities or obligations; 4) Succeeds or fails depending on the relation of receipts to expenditures; 5) Agrees to perform specific jobs for prices agreed upon in advance; and 6) Pays expenses incurred in connection with work performed.</td>
</tr>
<tr>
<td>Factor</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17) Does the worker provide services to more than one individual or firm at the same time?</td>
<td>If the worker provides services for a number of individuals or businesses at the same time, he is usually considered an independent contractor. As such, he is free from control by the individuals and businesses under whom he is employed. However, it is possible that an individual who works for several individuals or businesses may still be considered an employee of one or all of them.</td>
</tr>
<tr>
<td>18) Does worker make his services available to the general public?</td>
<td>If the services the worker performs are made available to the general public, the worker is usually considered an independent contractor. Services are made available to the general public by independent contractors in a variety of ways: 1) They may have their own office and assistants; 2) They may hang out a “shingle” in front of their home or office; 3) They may hold business licenses; 4) They may be listed in business directories; 5) They may maintain business listings in telephone directories; or 6) They may advertise in newspapers, trade journals, magazines, etc.</td>
</tr>
<tr>
<td>19) Can the worker be fired?</td>
<td>If the employer has the right to fire the worker, a factor of control exists, indicating an employer-employee relationship. On the other hand, independent contractors cannot be fired, provided that they meet their contractual requirements. Sometimes an employer’s right to fire is restricted because of a contract with a labor union. This restriction does not affect the existence of an employment relationship.</td>
</tr>
<tr>
<td>20) Does the worker have the right to end the relationship with the employer at any time?</td>
<td>If a worker can end the relationship with the employer at any time without liability, they are generally considered an employee. An independent contractor usually agrees to complete a specific job before ending the work relationship. An independent contractor is also personally and legally responsible for satisfactory completion of the job.</td>
</tr>
</tbody>
</table>
### Evidence Required to Claim Monthly Benefits

<table>
<thead>
<tr>
<th>If the beneficiary is...</th>
<th>Age</th>
<th>Relationships</th>
<th>Dependency or Support</th>
<th>School Attendance</th>
<th>Child-in-Care</th>
<th>Death of Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Marriage</td>
<td>Divorced</td>
<td>Parent-Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured person</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Spouse (62 or over)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Spouse (under 62, child-in-care)</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Divorced spouse (62 or over)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Child</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Widow(er) (60 or over, 50 or over if disabled)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Surviving divorced spouse</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mother/father or surviving divorced mother/father (child-in-care)</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Parent</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

1. See discussions elsewhere in this book for all the requirements for specific types of benefits.
2. If disability is involved, see “Evidence of Disability” in Lesson 5.
3. A legitimate or adopted child is ordinarily considered dependent on his parent; however, certain evidence may be needed in the case of other types of children.
4. Proof of full-time school attendance required if child is 18–19 and is not disabled.
5. For survivor claims.
6. Surviving divorced mother or father only.

### Evidence Required to Claim Lump-sum Death Payment

<table>
<thead>
<tr>
<th>If the beneficiary is...</th>
<th>Age</th>
<th>Relationships</th>
<th>Dependency or Support</th>
<th>School Attendance</th>
<th>Child-in-Care</th>
<th>Death of Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Marriage</td>
<td>Divorced</td>
<td>Parent-Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surviving spouse living in same household</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Eligible surviving spouse, excluding divorced spouse</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Eligible children</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

1. To qualify for the lump-sum, the claimant must present evidence that proves he does (or could) qualify for monthly benefits in the month the worker died.
2. A legitimate or adopted child is ordinarily considered dependent on his parent; however, certain evidence may be needed in the case of other types of children.
3. Proof of full-time school attendance required if child is 18–19 and is not disabled.
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm Screening</td>
<td>Medicare Part B covers a one-time screening ultrasound for people at risk. An individual is considered at risk if he has a family history of abdominal aortic aneurysms, or if he is a man age 65 to 75 and has smoked at least 100 cigarettes in his lifetime. Medicare only covers this screening if a patient gets a referral for it as a result of his “Welcome to Medicare” physical exam. The patient pays 20% of the Medicare-approved amount for the doctor’s services. In a hospital outpatient setting, he pays a copayment. The Part B deductible does not apply.</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Medicare does not cover acupuncture.</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Medicare Part B covers emergency ground ambulance transportation when an individual needs to be transported to a hospital or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger his health. Medicare will pay for emergency ambulance transportation in an airplane or helicopter to a hospital if an individual requires immediate and rapid ambulance transportation that ground transportation can not provide. Medicare will only cover ambulance services (ground or air) to the nearest appropriate medical facility that is able to provide necessary care. In some cases, Medicare may pay for limited non-emergency ambulance transportation if a patient has orders from his doctor saying that ambulance transportation is necessary because of his medical condition. An individual pays 20% of the Medicare-approved amount. All ambulance suppliers must accept assignment.</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers</td>
<td>Medicare Part B covers approved surgical procedures provided in an ambulatory surgical center. An individual pays 20% of the Medicare-approved amount (except for screening flexible sigmoidoscopies and screening colonoscopies, for which he will pay 25%). He pays all facility charges for procedures Medicare does not allow in ambulatory surgical centers.</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Medicare Part A covers anesthesia services provided by a hospital for an inpatient. Medicare Part B covers anesthesia services provided by a hospital for an outpatient or by a freestanding ambulatory surgical center for a patient. An individual pays 20% of the Medicare-approved amount for the anesthesia services provided by a doctor or certified registered nurse anesthetist. The anesthesia service must be associated with the underlying medical or surgical service.</td>
</tr>
<tr>
<td>Artificial Limbs and Eyes</td>
<td>Medicare Part B covers artificial limbs and eyes when ordered by a doctor. An individual pays 20% of the Medicare-approved amount.</td>
</tr>
<tr>
<td>Blood</td>
<td>Medicare Part A covers blood an individual gets as an inpatient. Medicare Part B covers blood he gets as a hospital outpatient. An individual pays either the provider costs for the first three units of blood received in a calendar year, or he must have the blood replaced (donated by the patient or someone else) if the provider has to buy blood for him. In most cases, the provider does not have to pay the blood bank for the blood, and the individual will not have to pay for it or replace it.</td>
</tr>
<tr>
<td>Blood Processing and Handling</td>
<td>Hospitals generally charge for blood processing and handling, whether the blood is donated or purchased. Medicare Part A covers this service for an inpatient. Medicare Part B covers this service for an outpatient. An individual pays a copayment for blood processing and handling services for every unit of blood he gets as a hospital outpatient.</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Bone Mass Measurement (Bone Density)</td>
<td>Medicare Part B covers bone mass measurements ordered by a doctor or qualified practitioner if a patient meets one or more of the following conditions:</td>
</tr>
<tr>
<td></td>
<td><strong>Women</strong></td>
</tr>
<tr>
<td></td>
<td>- The patient is at clinical risk for osteoporosis, based on medical history and other findings.</td>
</tr>
<tr>
<td></td>
<td><strong>Men and Women</strong></td>
</tr>
<tr>
<td></td>
<td>- The patient’s x-rays show possible osteoporosis, osteopenia or vertebrae fractures.</td>
</tr>
<tr>
<td></td>
<td>- The patient is on prednisone or steroid-type drugs or is planning to begin such treatment.</td>
</tr>
<tr>
<td></td>
<td>- The patient has been diagnosed with primary hyperparathyroidism.</td>
</tr>
<tr>
<td></td>
<td>- The patient is being monitored to see if his osteoporosis drug therapy is working.</td>
</tr>
<tr>
<td></td>
<td>The test is covered once every 24 months for qualified individuals and more often if medically necessary.</td>
</tr>
<tr>
<td></td>
<td>An individual pays $0 for the test if the doctor accepts assignment. In a hospital outpatient setting, he pays a copayment.</td>
</tr>
<tr>
<td>Braces</td>
<td>Medicare Part B covers arm, leg, back and neck braces. An individual pays 20% of the Medicare-approved amount.</td>
</tr>
<tr>
<td>Breast Prostheses</td>
<td>Medicare Part B covers external breast prostheses (including a post-surgical bra) after a mastectomy. Medicare Part A or Part B covers surgically implanted breast prostheses depending on whether the surgery takes place in an inpatient or outpatient setting. An individual pays 20% of the Medicare-approved amount for the doctor’s services and the external breast prostheses. For surgeries to implant breast prostheses in a hospital inpatient setting covered under Part A, see Hospital Care (Inpatient). For surgeries to implant breast prostheses in a hospital outpatient setting covered under Part B, see Outpatient Hospital Services.</td>
</tr>
<tr>
<td>Canes/Crutches</td>
<td>Medicare Part B covers canes and crutches. Medicare does not cover white canes for the blind. For more information, see Durable Medical Equipment (DME). An individual pays 20% of the Medicare-approved amount.</td>
</tr>
<tr>
<td>Cardiac Rehabilitation Program</td>
<td>Medicare Part B covers comprehensive programs that include exercise, education and counseling for patients whose doctor referred them and who had any of the following:</td>
</tr>
<tr>
<td></td>
<td>- A heart attack in the last 12 months.</td>
</tr>
<tr>
<td></td>
<td>- Coronary bypass surgery.</td>
</tr>
<tr>
<td></td>
<td>- Current stable angina pectoris (chest pain).</td>
</tr>
<tr>
<td></td>
<td>- Heart valve repair/replacement.</td>
</tr>
<tr>
<td></td>
<td>- Angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (device used to keep an artery open).</td>
</tr>
<tr>
<td></td>
<td>- A heart or heart-lung transplant Medicare Part B also covers intensive cardiac rehabilitation (ICR) programs that, like cardiac rehabilitation (CR) programs, include exercise, education and counseling for patients whose doctor referred them and who had any of the conditions listed above. ICR programs are typically more rigorous or more intense than CR programs. These programs may be provided in a hospital outpatient setting or in doctor-directed clinics.</td>
</tr>
<tr>
<td></td>
<td>An individual pays 20% of the Medicare-approved amount for the doctor’s services. In a hospital outpatient setting, he pays a copayment.</td>
</tr>
<tr>
<td>Cardiovascular Disease Screenings</td>
<td>Medicare Part B covers screening tests for cholesterol, lipid and triglyceride levels every five years to help an individual prevent a heart attack or stroke. An individual pays $0 for this test. He pays 20% of the Medicare-approved amount for the doctor’s visit.</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>Medicare Part A covers chemotherapy for cancer patients who are hospital inpatients. Medicare Part B covers chemotherapy for hospital outpatients or patients in a doctor’s office or freestanding clinic. An individual pays a copayment for chemotherapy covered under Part B in a hospital outpatient setting. For chemotherapy given in a doctor’s office or freestanding clinic, he pays 20% of the Medicare approved amount. For chemotherapy in the hospital inpatient setting covered under Part A, see Hospital Care (Inpatient).</td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>Medicare Part B covers manipulation of the spine if medically necessary to correct a subluxation (when one or more of the bones of an individual’s spine move out of position) when provided by a chiropractor or other qualified provider. An individual pays 20% of the Medicare-approved amount. He pays all costs for any services or tests ordered by a chiropractor.</td>
</tr>
<tr>
<td><strong>Clinical Research Studies</strong></td>
<td>Clinical research studies test different types of medical care, like how well a cancer drug works. These studies help doctors and researchers see if new care works and if it is safe. Medicare Part A and/or Part B covers some costs, such as doctor visits and tests, in a qualifying clinical research study. An individual pays the part of the payment that he normally would pay for covered services (generally 20% of the Medicare-approved amount).</td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screening</strong></td>
<td>Medicare Part B covers several colorectal cancer screening tests to help find precancerous growths and help prevent or find cancer early. All people 50 and older with Medicare are covered. There’s no minimum age for having a colonoscopy, however. <strong>Barium enema.</strong> When this test is used instead of a flexible sigmoidoscopy or colonoscopy, Medicare covers the test once every 48 months for people age 50 or over and once every 24 months for people at high risk for colorectal cancer. An individual pays 20% of the Medicare-approved amount for the doctor’s services. In a hospital outpatient setting, he pays a copayment. The Part B deductible does not apply. <strong>Colonoscopy.</strong> Medicare covers this test once every 24 months if an individual is at high risk for colorectal cancer. If he is not at high risk for colorectal cancer, Medicare covers the test once every 120 months or 48 months after a screening flexible sigmoidoscopy. An individual pays $0 for this test if the doctor accepts assignment. <strong>Fecal occult blood test.</strong> Medicare covers this lab test once every 12 months for people 50 or older. An individual pays $0 for this test, but he generally has to pay 20% of the Medicare-approved amount for the doctor’s visit. The Part B deductible does not apply. <strong>Flexible sigmoidoscopy.</strong> Medicare covers this test once every 48 months for most people 50 or older. For those not at high risk, Medicare covers this test 120 months after a previous screening colonoscopy. An individual pays $0 for this test if the doctor accepts assignment.</td>
</tr>
<tr>
<td><strong>Commode Chairs</strong></td>
<td>Medicare Part B covers commode chairs that a doctor orders for use in a patient’s home if he is confined to his bedroom. For more information, see Durable Medical Equipment (DME). An individual pays 20% of the Medicare-approved amount.</td>
</tr>
<tr>
<td><strong>Cosmetic Surgery</strong></td>
<td>Medicare generally does not cover cosmetic surgery unless it is needed because of accidental injury or to improve the function of a malformed body part. Medicare covers breast reconstruction if an individual had a mastectomy because of breast cancer.</td>
</tr>
<tr>
<td><strong>Custodial Care (help with activities of daily living)</strong></td>
<td>Medicare does not cover custodial care when it is the only kind of care an individual needs. Care is considered custodial when it helps an individual with activities of daily living or personal needs and could be done safely and reasonably by people without professional skills or training.</td>
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<td>Service</td>
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<tr>
<td>Defibrillator (Implantable Automatic)</td>
<td>Medicare Part A or Part B covers defibrillators for certain people diagnosed with heart failure depending on whether the surgery takes place in a hospital inpatient or outpatient setting. An individual pays 20% of the Medicare-approved amount for the doctor’s services. He pays a copayment but no more than the Part A hospital stay deductible if he gets the defibrillator as a hospital outpatient. For surgeries to implant defibrillators in the hospital inpatient setting covered under Part A, see Hospital Care (Inpatient).</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, dentures, dental plates or other dental devices. Medicare Part A will pay for certain dental services that an individual gets while in a hospital. Medicare Part A can pay for hospital stays if an individual needs to have emergency or complicated dental procedures, even when the dental care is not covered.</td>
</tr>
<tr>
<td>Diabetes Screenings</td>
<td>Medicare Part B covers tests to check for diabetes. These tests are available if an individual has any of the following risk factors: high blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity or a history of high blood sugar. Medicare also covers these tests if two or more of the following apply to an individual: • Age 65 or older. • Overweight. • Family history of diabetes (parents, brothers, sisters). • A history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than nine pounds. Based on the results of these tests, she may be eligible for up to two diabetes screenings every year. An individual pays $0 for this test, but generally has to pay 20% of the Medicare-approved amount for the doctor’s visit.</td>
</tr>
<tr>
<td>Diabetes Supplies and Services</td>
<td>Medicare Part B covers some diabetes supplies, including the following: • Blood sugar (glucose) test strips. • Blood sugar monitor. • Lancet devices and lancets. • Glucose control solutions for checking test strip and monitor accuracy. There may be limits on how much or how often an individual gets these supplies. For more information, see Durable Medical Equipment (DME). An individual pays 20% of the Medicare-approved amount. <strong>Insulin.</strong> Medicare Part B does not cover insulin (unless used with an insulin pump), insulin pens, syringes, needles, alcohol swabs, or gauze. Insulin and certain medical supplies used to inject insulin, such as syringes, gauze, and alcohol swabs may be covered under Part D. If an individual uses an external insulin pump, then insulin and the pump may be covered as durable medical equipment. See Durable Medical Equipment (DME). An individual pays 100% for insulin unless used with an insulin pump (then he pays 20% of the Medicare-approved amount) and 100% for syringes and needles, unless he has Part D. <strong>Therapeutic shoes or inserts.</strong> Medicare Part B covers therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. The doctor who treats the individual’s diabetes must certify that individual’s need for therapeutic shoes or inserts. The shoes and inserts must be prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist or pedorthist. Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year. Shoe modifications may be substituted for inserts. Medicare covers the fitting of the shoes or inserts for the shoes. An individual pays 20% of the Medicare-approved amount.</td>
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### List of Services Covered By Medicare Parts A and B (Continued)

<table>
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<tr>
<th>Service</th>
<th>Description</th>
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</table>
| **Diabetes Supplies and Services (cont.)** | Medicare covers these diabetes services:  
**Diabetes self-management training.** Medicare Part B covers diabetes outpatient self-management training to teach an individual how to manage diabetes. It includes education about how to monitor blood sugar, diet, exercise and insulin. If an individual has been diagnosed with diabetes, Medicare may cover up to 10 hours of initial diabetes self-management training. He may also qualify for up to two hours of follow-up training each year if the following conditions are met:  
- † **Note:** Some exceptions apply if no group session is available or if an individual’s doctor or qualified provider says that individual has special needs that prevent him from participating in group training. It lasts for at least 30 minutes.  
  - It’s provided in a group of two to 20 people.  
  - It takes place in a calendar year after the year an individual got his initial training.  
  - An individual’s doctor or a qualified provider ordered it as part of his plan of care.  
  An individual pays 20% of the Medicare-approved amount.  
**Yearly eye exam.** Medicare Part B covers a yearly eye exam for diabetic retinopathy by an eye doctor who is legally allowed by the state to do the test.  
An individual pays 20% of the Medicare-approved amount for the doctor’s services. In a hospital outpatient setting, he pays a copayment.  
**Foot exam.** Medicare Part B covers a foot exam every six months for people with diabetic peripheral neuropathy and loss of protective sensations, as long as they have not seen a foot care professional for another reason between visits.  
An individual pays 20% of the Medicare-approved amount for the doctor’s services. In a hospital outpatient setting, he pays a copayment.  
**Glaucoma tests.** See *Glaucoma Tests*.  
**Medical nutrition therapy services.** See *Nutritional Therapy Services (Medical)*. |
| **Diagnostic Tests, X-Rays and Clinical Laboratory Services** | Medicare Part B covers diagnostic tests like CT scans, MRIs, EKGs and x-rays when an individual’s doctor or health care provider orders them as part of treating a medical problem. Medicare also covers clinical diagnostic laboratory services provided by certified laboratories enrolled in Medicare. Diagnostic tests and lab services are done to help a doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, such as checking hearing. Medicare covers some preventive tests and screenings to help prevent, find or manage a medical problem. For more information, see *Preventive Services*.  
An individual pays 20% of the Medicare-approved amount for covered diagnostic tests and x-rays done in a doctor’s office or independent testing facility. He pays a copayment for diagnostic tests and x-rays in the hospital outpatient setting. He pays $0 for Medicare-covered lab services. |
| **Dialysis (Kidney) Services and Supplies** | Medicare covers some kidney dialysis services and supplies for people with end-stage renal disease (ESRD).  
**Inpatient dialysis treatments.** Medicare Part A covers dialysis if an individual is admitted to the hospital for special care. See *Hospital Care (Inpatient)*.  
**Outpatient maintenance dialysis treatments.** Medicare Part B covers dialysis if an individual needs regular treatments, and he receives treatments in any Medicare-approved dialysis facility.  
An individual pays 20% of the Medicare-approved amount.  
**Certain home dialysis support services.** Medicare Part B covers visits by trained dialysis workers to check on an individual’s home dialysis, to help in dialysis emergencies when needed, and to check his dialysis equipment and hemodialysis water supply.  
An individual pays 20% of the Medicare-approved amount. Only dialysis facilities can furnish home dialysis support services.  
**Certain drugs for home dialysis.** Medicare Part B covers heparin, the antidote for heparin when medically necessary, and topical anesthetics. |
List of Services Covered By Medicare Parts A and B (Continued)

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<th>Service</th>
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<tr>
<td><strong>Dialysis (Kidney) Services and Supplies</strong></td>
<td>An individual pays 20% of the Medicare-approved amount, if he deals with a supplier. If he deals with a dialysis facility, these drugs are included in the cost of dialysis. Erythropoiesis-stimulating agents. Medicare covers agents like Epogen®, Epoetin alfa, Aranesp® or Darbepoetin alfa to treat anemia if an individual has end-stage renal disease. An individual pays 20% of the Medicare-approved amount. Self-dialysis training. Medicare Part B covers training for an individual and the person helping him with his home dialysis treatments. An individual pays 20% of the Medicare-approved amount. Home dialysis equipment and supplies. Medicare Part B covers equipment and supplies like alcohol, wipes, sterile drapes, rubber gloves and scissors. An individual pays 20% of the Medicare-approved amount. If he deals with a dialysis facility, the cost of home dialysis equipment and supplies is included in the cost of dialysis. If he deals with a medical supply company, it (not the dialysis facility) must accept assignment.</td>
</tr>
<tr>
<td><strong>Doctor’s Services</strong></td>
<td>Medicare Part B covers medically necessary services or covered preventive services he receives from his doctor in the doctor’s office, in a hospital, in a skilled nursing facility, in the patient’s home or any other location. Medicare does not cover routine physicals, except the one-time “Welcome to Medicare” physical exam. Medicare covers some preventive tests and screenings. See Preventive Services. An individual pays 20% of the Medicare-approved amount.</td>
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<tr>
<td><strong>Drugs</strong></td>
<td>See Prescription Drugs (Outpatient) Limited Coverage.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>Medicare Part B covers DME that a doctor prescribes for use in an individual’s home. Only a doctor can prescribe medical equipment. DME meets the following criteria:</td>
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<td>• Durable (long lasting).</td>
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<td>• Used for a medical reason.</td>
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<td>• Not usually useful to someone who is not sick or injured.</td>
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<td>• Used in the home.</td>
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<td>The DME that Medicare covers includes, but is not limited to:</td>
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<td>• Air-fluidized beds.</td>
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<td>• Blood sugar monitors.</td>
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<td>• Canes (white canes for the blind aren’t covered).</td>
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<td>• Commode chairs.</td>
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<tr>
<td></td>
<td>• Crutches.</td>
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<tr>
<td></td>
<td>• Dialysis machines.</td>
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<td>• Home oxygen equipment and supplies.</td>
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<td>• Hospital beds.</td>
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<td>• Infusion pumps (and some medicines used in infusion pumps if considered reasonable and necessary).</td>
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<tr>
<td></td>
<td>• Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary).</td>
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<td>• Patient lifts (to lift patient from bed or wheelchair by hydraulic operation).</td>
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<td>• Suction pumps.</td>
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<td>• Traction equipment.</td>
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<td>• Walkers.</td>
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<td>• Wheelchairs.</td>
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<td>An individual should make sure his doctor or supplier is enrolled in Medicare. Doctors and other suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If a doctor or supplier</td>
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<td>Service</td>
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<td><strong>Durable Medical Equipment (DME) (cont.)</strong></td>
<td>is not enrolled, Medicare will not pay the claim submitted by that doctor or supplier, even if the supplier is a large chain or department store that sells more than just durable medical equipment. An individual pays 20% of the Medicare-approved amount. Medicare pays for different kinds of DME in different ways; some equipment must be rented, other equipment may be purchased and individuals may choose to rent or buy some equipment. If a DME supplier does not accept assignment, Medicare does not limit how much the supplier can charge an individual. Individuals also may have to pay the entire bill (their share and Medicare’s share) at the time they get the DME.</td>
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<td><em>Note:</em> An individual should ask if the supplier is a participating supplier in the Medicare Program before he gets DME. If the supplier is a participating supplier, it must accept assignment. If the supplier is enrolled in Medicare but is not “participating,” it may choose not to accept assignment. To find suppliers who accept assignment, go to <a href="http://www.medicare.gov">www.medicare.gov</a> and select, “Find Suppliers of Medical Equipment in Your Area.”</td>
</tr>
<tr>
<td>EKG Screening</td>
<td>Medicare Part B covers a one-time screening EKG if an individual gets a referral for it as a result of his one-time “Welcome to Medicare” physical exam. See Physical Exams. An EKG is also covered as a diagnostic test. An individual pays 20% of the Medicare-approved amount.</td>
</tr>
<tr>
<td>Emergency Department Services</td>
<td>Medicare Part B covers emergency department services. Emergency services may be covered in foreign countries only in rare circumstances. For more information, see Travel. A medical emergency is when an individual believes that he has an injury or illness that requires immediate medical attention to prevent a disability or death. An individual pays a copayment for each emergency department visit unless he is admitted to the same hospital for the same condition within three days of his emergency department visit. When an individual goes to an emergency department, he pays a copayment for each hospital service. He also pays 20% of the Medicare-approved amount for the doctor’s services.</td>
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<tr>
<td>Equipment</td>
<td>See Durable Medical Equipment (DME).</td>
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<tr>
<td>Eye Exams</td>
<td>Medicare does not cover routine eye exams (refractions) for eye glasses/contact lenses. Medicare covers some preventive and diagnostic eye exams:</td>
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<td>• See Yearly eye exam under Diabetes Supplies and Services.</td>
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<td>• See Glaucoma Tests.</td>
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<td>• See Macular Degeneration.</td>
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<tr>
<td>Eyeglasses/Contact Lenses</td>
<td>Generally, Medicare does not cover eyeglasses or contact lenses. Following cataract surgery with an implanted intraocular lens, however, Medicare Part B helps pay for corrective lenses (eyeglasses or contact lenses). An individual pays 100% in general. He pays 20% of the Medicare-approved amount for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. He pays any additional cost for upgraded frames.</td>
</tr>
<tr>
<td>Eye Refractions</td>
<td>Medicare does not cover routine eye refractions for eye glasses/contacts. See Eye Exams.</td>
</tr>
<tr>
<td>Flu Shots</td>
<td>Medicare Part B normally covers one flu shot per flu season in the fall or winter. An individual pays $0 for a flu shot if the doctor or supplier accepts assignment for administering the shot. If the doctor or supplier does not accept assignment, the individual pays 20% of the Medicare-approved amount.</td>
</tr>
<tr>
<td>Foot Care</td>
<td>Medicare Part B covers the services of a podiatrist (foot doctor) for medically necessary treatment of injuries or diseases of the foot (such as hammer toe, bunion deformities and heel spurs), but it does not cover routine foot care. See Therapeutic Shoes and Foot Exam under Diabetes Supplies and Services.</td>
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<td>Service</td>
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<tr>
<td>Foot Care (cont.)</td>
<td>An individual pays 100% for routine foot care in most cases. He pays 20% of the Medicare-approved amount for medically necessary treatment provided by a doctor. In a hospital outpatient setting, he pays a copayment for medically necessary treatment.</td>
</tr>
<tr>
<td>Glaucoma Tests</td>
<td>Medicare Part B covers a glaucoma test once every 12 months for people at high risk for glaucoma. This includes people with diabetes, a family history of glaucoma, African Americans 50 and older and Hispanic Americans 65 and older. The screening must be done or supervised by an eye doctor who is legally allowed to do this test in the state in which the individual lives. An individual pays 20% of the Medicare-approved amount for the doctor’s services. In a hospital outpatient setting, he pays a copayment.</td>
</tr>
<tr>
<td>Health Education/Wellness Programs</td>
<td>Medicare generally does not cover health education and wellness programs. Medicare does cover medical nutrition therapy for people with diabetes or kidney disease and diabetes education for people with diabetes, counseling to stop smoking and a one-time “Welcome to Medicare” physical exam.</td>
</tr>
<tr>
<td>Hearing and Balance Exams/Hearing Aids</td>
<td>In some cases, Medicare Part B covers diagnostic hearing and balance exams. Medicare does not cover routine hearing exams, hearing aids or exams for fitting hearing aids. An individual pays 100% for routine exams and hearing aids. He pays 20% of the Medicare-approved amount for the doctor’s services for covered exams. In a hospital outpatient setting, he pays a copayment.</td>
</tr>
<tr>
<td>Hepatitis B Shots</td>
<td>Medicare Part B covers this shot for people at high or medium risk for Hepatitis B. An individual’s risk for Hepatitis B increases if he has hemophilia, end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant) or a condition that lowers his resistance to infection. Other factors may also increase his risk for Hepatitis B. An individual should check with his doctor to see if he is at high or medium risk for Hepatitis B. An individual pays $0 for the shot if the doctor accepts assignment.</td>
</tr>
<tr>
<td>HIV Screening</td>
<td>Starting December 8, 2009, Medicare Part B covers HIV screening for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. An individual pays $0 for the test, but he generally pays 20% of the Medicare-approved amount for the doctor’s visit.</td>
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</table>
| Home Health Services  | An individual can use his home health benefits under Medicare Part A and/or Part B if he meets all the following conditions:  
  - His doctor decides he needs medical care at home and makes a plan for it.  
  - He needs at least one of the following, qualifying skilled services:  
    - Intermittent skilled nursing care (other than just drawing blood).  
    - Physical therapy.  
    - Speech-language pathology services.  
    - Continued occupational therapy.  
  - The home health agency caring for him is Medicare-certified.  
  - He must be homebound, meaning that he is normally unable to leave home unassisted. When he does leave the home, it is a considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to attend religious services. He can still receive home health care if he attends adult day care.  
  ➤ Note: Home health services may also include part-time or intermittent home health aide services, medical social services, medical supplies, durable medical equipment and an injectable osteoporosis drug. An individual pays $0 for all covered home health visits. |
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<tr>
<td><strong>Home Health Services (cont.)</strong></td>
<td><strong>Osteoporosis drugs for women.</strong> Medicare Part A and B help pay for an injectable drug for osteoporosis in women who are eligible for Medicare Part B, meet the criteria for Medicare home health services and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. She must also be certified by a doctor as unable to learn or unable to give herself the drug by injection, and that family and/or caregivers are unable or unwilling to give the drug by injection. Medicare covers the visit by a home health nurse to give the drug. An individual pays 20% of the Medicare-approved amount for the cost of the drug. She pays $0 for the home health nurse visit to give the drug.</td>
</tr>
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</table>
| **Hospice Care** | Medicare Part A covers hospice care if an individual meets all of the following conditions:  
- He is eligible for Medicare Part A.  
- His doctor certifies that he is terminally ill and probably has less than six months to live.  

**Note:** In a Medicare-approved hospice, nurse practitioners are not permitted to certify the patient’s terminal diagnosis, but after a doctor certifies the diagnosis, the nurse practitioner can serve in place of an attending doctor. The individual can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that he is terminally ill.  
- He accepts palliative care (for comfort) instead of care to cure his illness.  
- He signs a statement choosing hospice care instead of routine Medicare-covered benefits for his terminal illness.  

**Inpatient respite care.** Respite care is inpatient care given to a hospice patient so that the usual caregiver can rest. The individual can stay in a Medicare approved facility, such as a hospice facility, hospital or nursing home, up to five days each time he gets respite care. Medicare will still pay for covered benefits for any health problems that are not related to his terminal illness. An individual pays $0 for hospice care. He may need to pay a copayment of up to $5 for outpatient prescription drugs for symptom control or pain relief. Medicare does not cover room and board when he gets hospice care in his home or another facility where he lives (such as a nursing home). In certain cases, if the hospice staff determines that an individual needs inpatient care in a hospice facility or his caregiver needs a short period of respite, Medicare covers the costs for room and board. He pays 5% of the Medicare-approved amount for inpatient respite care. |
| **Hospital Bed** | See *Durable Medical Equipment (DME).* |
| **Hospital Care (Inpatient)** | For outpatient services, Medicare Part A covers inpatient hospital care when all of the following are true:  
- A doctor says an individual needs inpatient hospital care to treat his illness or injury.  
- He needs the kind of care that can be given only in a hospital.  
- The hospital accepts Medicare.  
- The Utilization Review Committee of the hospital approves his stay while he is in the hospital.  

Medicare-covered hospital services include a semiprivate room, meals, general nursing and other hospital services and supplies. This includes care received in critical access hospitals and inpatient mental health care. This does not include private-duty nursing, a television or a telephone in the room and personal care items like razors or slipper socks. It also does not include a private room, unless medically necessary.  
In 2011, an individual pays for each benefit period:  
- *Days 1–60:* $1,132 deductible.  
- *Days 61–90:* $283 coinsurance each day.  
- *Days 91–150:* $566 coinsurance each day.  
- *Beyond 150 days:* all costs.  

An individual pays for private-duty nursing, a television or a telephone in his room. He pays for a private room unless it is medically necessary. |
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<tr>
<td>Kidney (Dialysis)</td>
<td>See Dialysis (Kidney) Services and Supplies.</td>
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<tr>
<td>Kidney Disease Education</td>
<td>Starting January 1, 2010, Medicare covers Kidney Disease Education services if an individual has stage IV chronic kidney disease. Kidney Disease Education teaches him things he can do to take the best possible care of his kidneys and gives him information he needs to make informed decisions about his care. Medicare covers up to six sessions of Kidney Disease Education services when given by a doctor, certain non-doctor providers or a rural provider. An individual pays 20% of the Medicare-approved amount per session if he gets the service from a doctor or other health care provider.</td>
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<tr>
<td>Laboratory Services (Clinical)</td>
<td>Medicare Part B covers medically necessary diagnostic lab services that are ordered by a treating doctor. Services include certain blood tests, urinalysis, some screening tests and more. They must be provided by a laboratory that meets Medicare requirements. For more information, see Diagnostic Tests, X-Rays and Clinical Laboratory Services. An individual pays $0 for Medicare-approved lab services.</td>
</tr>
<tr>
<td>Macular Degeneration</td>
<td>Medicare Part B covers certain diagnoses and treatment of diseases and conditions of the eye for some patients with age-related macular degeneration (AMD) like ocular photodynamic therapy with verteporfin (Visudyne®). An individual pays 20% of the Medicare-approved amount for the doctor’s services. In a hospital outpatient setting, he pays a copayment.</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Medicare Part B covers a screening mammogram once every 12 months (11 full months must have gone by from the last screening) for all women with Medicare who are 40 and older. An individual can also get one baseline mammogram between 35 and 39. An individual pays %0 for the test if the doctor accepts assignment.</td>
</tr>
<tr>
<td>Medical Nutrition Therapy Services</td>
<td>See Nutrition Therapy Services (Medical).</td>
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</tbody>
</table>
| Mental Health Care                           | Medicare Part A and Part B cover mental health services in a variety of settings.  
**Inpatient mental health care.** Medicare Part A covers inpatient mental health care services. These services can be given in hospitals, including specialized psychiatric units or specialized psychiatric hospitals. Medicare helps pay for inpatient mental health services in the same way that it pays for all other inpatient hospital care.  
:::  
**Note:** If an individual is in a specialty psychiatric hospital, Medicare only helps pay for a total of 190 days of inpatient care during his lifetime.  
**Outpatient mental health care.** Medicare Part B covers mental health services on an outpatient basis when provided by a doctor, clinical psychologist, clinical social worker, nurse practitioner, clinical nurse specialist or physician assistant in an office setting, clinic or hospital outpatient setting. An individual pays 20% of the Medicare-approved amount for visits to a doctor or other health care provider to diagnose his condition or to monitor or change his prescriptions. An individual pays 45% (which decreases in future years) of the Medicare-approved amount for outpatient treatment of his conditions (such as counseling or psychotherapy) in a doctor’s office setting. This coinsurance amount will continue to decrease over the next four years. In a hospital outpatient setting, he pays a copayment.  
**Partial hospitalization.** Medicare Part B covers partial hospitalization in some cases. It is a structured program of outpatient active psychiatric treatment that is more intense than the care an individual gets in his doctor’s or therapist’s office. To be eligible for a partial hospitalization program, a doctor must certify that an individual would otherwise need inpatient treatment. |
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<td>Mental Health Care (cont.)</td>
<td>An individual pays a percentage of the Medicare-approved amount for each service he gets from a qualified professional (as described in Outpatient mental health care above). He also pays 20% of the Medicare-approved amount for each day of service when provided in a hospital outpatient setting or community mental health center.</td>
</tr>
<tr>
<td>Non-Doctor Services</td>
<td>Medicare Part B covers certain services provided by health care professionals who are not doctors such as clinical social workers, nurse practitioners and physician assistants. An individual pays 20% of the Medicare-approved amount.</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>Most nursing home care is custodial care (such as help with bathing or dressing). Medicare does not cover custodial care if that is the only care needed. If it is medically necessary for an individual to have skilled care (like changing sterile dressings), Medicare Part A will pay for care given in a certified skilled nursing facility (SNF). See Skilled Nursing Facility (SNF) Care.</td>
</tr>
<tr>
<td>Nutrition Therapy Services (Medical)</td>
<td>Medicare Part B covers medical nutrition therapy services, when ordered by a doctor, for people with kidney disease (but who are not on dialysis), people who have a kidney transplant or people with diabetes. If an individual receives dialysis in a dialysis facility, Medicare covers medical nutrition therapy as part of his overall dialysis care. A registered dietitian or Medicare-approved nutrition professional can give these services. Services may include nutritional assessment, one-on-one counseling and therapy through an interactive telecommunications system. See Diabetes Supplies and Services. An individual pays $0 for these services if the doctor accepts assignment.</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>See Physical Therapy/Occupational Therapy/Speech-Language Pathology Services.</td>
</tr>
<tr>
<td>Orthotics</td>
<td>Medicare Part B covers artificial limbs and eyes and arm, leg, back and neck braces. Medicare does not pay for orthopedic shoes unless they are a necessary part of the leg brace. Medicare does not pay for dental plates or other dental devices. See Therapeutic shoes or inserts under Diabetes Supplies and Services. An individual must go to a supplier that is enrolled in Medicare for Medicare to cover his orthotics. An individual pays 20% of the Medicare-approved amount.</td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>Medicare Part B covers ostomy supplies for people who have had a colostomy, ileostomy or urinary ostomy. Medicare covers the amount of supplies a doctor says is needed, based on a patient’s condition. An individual pays 20% of the Medicare-approved amount for the doctor’s services and supplies.</td>
</tr>
</tbody>
</table>
| Outpatient Hospital Services        | Medicare Part B covers medically necessary services an individual receives as an outpatient from a Medicare-participating hospital for diagnosis or treatment of an illness or injury. Covered outpatient hospital services include the following:  
  • Services in an emergency department or outpatient clinic, including same-day surgery.  
  • Laboratory tests billed by the hospital.  
  • Mental health care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.  
  • X-rays and other radiology services billed by the hospital.  
  • Medical supplies such as splints and casts.  
  • Screenings and preventive services.  
  • Certain drugs and biologicals that an individual can not give himself.  
An individual pays 20% of the Medicare-approved amount for the doctor’s services. For other than doctors’ services, he pays a copayment for each service he gets in an outpatient hospital setting. |
### List of Services Covered By Medicare Parts A and B (Continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
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</table>
| **Oxygen Therapy**               | Medicare Part B covers the rental of oxygen equipment. If an individual owns his own equipment, Medicare will help pay for oxygen contents and supplies for the delivery of oxygen when all of the conditions below are met:  
  - His doctor says he has a severe lung disease, or he is not getting enough oxygen.  
  - He might improve with oxygen therapy.  
  - His arterial blood gas level falls within a certain range.  
  - Other alternative measures have failed.  
Under the above conditions Medicare helps pay for the following:  
  - Systems for furnishing oxygen.  
  - Containers that store oxygen.  
  - Tubing and related supplies for the delivery of oxygen and oxygen contents.  
An individual pays 20% of the Medicare-approved amount. |
| **Pap Test/Pelvic Exam (Screening)** | Medicare Part B covers Pap tests and pelvic exams (and a clinical breast exam) for all women once every 24 months. Medicare covers this test and exam once every 12 months if an individual is at high risk for cervical or vaginal cancer or if she is of childbearing age and has had an abnormal Pap test in the past 36 months.  
An individual pays $0 for the lab Pap test, Pap test specimen collection and pelvic and breast exams if the doctor accepts assignment. |
| **Physical Exams**               | Medicare Part B covers a one-time “Welcome to Medicare” physical exam, which includes a review of an individual’s health, as well as education and counseling about the preventive services he needs (including certain screenings and shots) and referrals for other care if needed. Medicare does not cover routine physical exams.  
**Caution:** An individual must have the physical exam within the first 12 months he has Medicare Part B. When he makes his appointment, he should let his doctor’s office know he would like to schedule his “Welcome to Medicare” physical exam. The Part B deductible does not apply.  
An individual who has had Medicare Part B for more than a year can get a yearly “wellness” exam at no cost, beginning January 1, 2011. This exam is covered once every 12 months. |
| **Physical Therapy/Occupational Therapy/Speech-Language Pathology Services** | Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy and speech-language pathology services when both of these conditions are met:  
  - An individual’s doctor or therapist sets up the plan of treatment.  
  - His doctor periodically reviews the plan to see how long he will need therapy.  
An individual can receive outpatient physical therapy/occupational therapy/speech-language pathology services from a Medicare-approved outpatient provider such as a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or a comprehensive outpatient rehabilitation facility. Also, he can receives services from a Medicare-approved physical or occupational therapist, in private practice, in the professional’s office or in the patient’s home. Medicare does not pay for services given by a speech-language pathologist in private practice.  
There may be limits on physical therapy, occupational therapy and speech-language pathology services. If so, there may be exceptions to these limits. An individual pays 20% of the Medicare-approved amount. |
| **Pneumococcal Shot**            | Medicare Part B covers a pneumococcal shot to help prevent pneumococcal infections (such as certain types of pneumonia). Most people only need this preventive shot once in their lifetime. An individual should talk with his doctor to see if he need this shot.  
An individual pays $0 for a pneumococcal shot if the doctor or supplier accepts assignment for giving the shot. |
### List of Services Covered By Medicare Parts A and B (Continued)

<table>
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<tr>
<th>Service</th>
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<tbody>
<tr>
<td><strong>Prescription Drugs (Outpatient) Limited Coverage</strong></td>
<td>Part B covers a limited number of outpatient prescription drugs, and only under limited conditions. Generally these include drugs an individual would not usually give to himself and that he gets at a doctor’s office or hospital outpatient setting. Doctors and pharmacies must accept assignment for Part B drugs, so a patient should never be asked to pay more than the coinsurance or copayment for the drug itself. The following are examples of drugs covered by Part B:</td>
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<tr>
<td>- <strong>Infused drugs.</strong> Medicare covers drugs infused through an item of durable medical equipment, such as an infusion pump or nebulizer, if considered reasonable and necessary.</td>
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<tr>
<td>- <strong>Some antigens.</strong> Medicare will help pay for antigens if they are prepared by a provider and given by a properly instructed person (who could be the patient) under appropriate supervision.</td>
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<tr>
<td>- <strong>Injectable osteoporosis drugs.</strong> Medicare helps pay for an injectable drug for osteoporosis for certain women with Medicare. See Osteoporosis drugs for women under Home Health Services.</td>
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<tr>
<td>- <strong>Erythropoisis-stimulating agents.</strong> Medicare will help pay for erythropoietin by injection if an individual has end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant) or needs this drug to treat anemia related to certain other conditions.</td>
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<tr>
<td>- <strong>Blood clotting factors.</strong> If an individual has hemophilia, Medicare will help pay for clotting factors he gives himself by injection.</td>
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<tr>
<td>- <strong>Injectable drugs.</strong> Medicare covers most injectable drugs given by a licensed medical provider, if the drug is considered reasonable and necessary for treatment.</td>
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<tr>
<td>- <strong>Immunosuppressive drugs.</strong> Medicare covers immunosuppressive drug therapy for transplant patients if the transplant meets Medicare coverage requirements, the patient is enrolled in Part A at the time of the transplant, and the patient is enrolled in Medicare Part B at the time the drugs are dispensed. Note: Medicare drug plans may cover immunosuppressive drugs, even if Medicare or an employer or union group health plan did not pay for the transplant.</td>
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<tr>
<td>- <strong>Oral cancer drugs.</strong> Medicare will help pay for some cancer drugs an individual takes by mouth if the same drug is available in injectable form. Currently, Medicare covers the following cancer drugs taken by mouth:</td>
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<td>- Capecitabine (Xeloda®).</td>
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<td>- Melphalan (Alkeran®).</td>
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<tr>
<td>- Busulfan (Myleran®).</td>
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<td>- Temozolomide (Temodar®).</td>
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<td>- Cyclophosphamide (Cytoxan®).</td>
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<td>- Topotecan (Hycamtin®).</td>
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<td>- Etoposide (VePesid®).</td>
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<tr>
<td>- Methotrexate (Rheumatrex®, Trexall®).</td>
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<td>Medicare may cover new cancer drugs as they become available.</td>
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<tr>
<td>- <strong>Oral anti-nausea drugs.</strong> Medicare will help pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered immediately before, at or within 48 hours and must be used as a full therapeutic replacement for the intravenous anti-nausea drugs that would otherwise be given.</td>
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<tr>
<td>An individual pays 20% of the Medicare-approved amount for covered Part B prescription drugs that he receives in a doctor’s office or pharmacy. In a hospital outpatient setting, he pays a copayment. If he receives drugs in a hospital outpatient setting that are not covered under Part B, however, he pays 100% for the drugs unless he has Part D or other prescription drug coverage. In that case, what he pays depends on whether his drug plan covers the drug, and whether the hospital is in his drug plan’s network. He should contact his prescription drug plan to find out what he pays for drugs he receives in a hospital outpatient setting.</td>
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<td><strong>Preventive Services</strong></td>
<td>Medicare Part B covers the following preventive and screening services that may help prevent illness or detect illness at an early stage, when treatment is likely to work best:</td>
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<tr>
<td>- Abdominal aortic aneurysm screening.</td>
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<td>Preventive Services (cont.)</td>
<td>• Bone mass measurement.</td>
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<td>• Cardiovascular disease screenings.</td>
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<td>• Colorectal cancer screening.</td>
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<td>• Diabetes screening.</td>
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<td>• Diabetes self-management training.</td>
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<td>• Glaucoma tests.</td>
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<td>• HIV screening.</td>
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<td>• Mammogram (screening).</td>
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<td>• Medical nutrition therapy services.</td>
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<td>• Pap test/pelvic exam (screening).</td>
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<td></td>
<td>• Physical exams.</td>
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<td>• Prostate cancer screening.</td>
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<td>• Shots including the following:</td>
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<td>• Flu shot.</td>
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<td>• Pneumococcal shot.</td>
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<td>• Hepatitis B shot.</td>
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<td>• Smoking cessation counseling.</td>
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<td>An individual pays the cost for that specific service shown elsewhere in this table.</td>
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</table>

**Prostate Cancer Screenings**  
Medicare Part B covers prostate cancer screening tests once every 12 months for men with Medicare who are 50 and older. Coverage begins the day after an individual’s 50th birthday. Covered tests include the following:

**Digital rectal examination.** An individual generally pays 20% of the Medicare-approved amount for the digital rectal exam for the doctor’s services. In a hospital outpatient setting, he pays a copayment.

**Prostate specific antigen (PSA) test.** An individual pays $0 for the PSA test.

**Prosthetic Devices**  
Medicare Part B covers prosthetic devices needed to replace an internal body part or function. These include Medicare-approved corrective lenses needed after a cataract operation (see Eyeglasses/Contact Lenses), ostomy bags and certain related supplies (see Ostomy Supplies) and breast prostheses (including a surgical bra) after a mastectomy (see Breast Prostheses). An individual must go to a supplier that is enrolled in Medicare for Medicare to pay for his device. Medicare Part A or Medicare Part B covers surgically implanted prosthetic devices depending on whether the surgery takes place in an inpatient or outpatient setting.

An individual pays 20% of the Medicare-approved amount for external prosthetic devices. For surgeries to implant prosthetic devices in a hospital inpatient setting covered under Part A, see Hospital Care (Inpatient). For surgeries to implant prosthetic devices in a hospital outpatient setting covered under Part B, see Outpatient Hospital Services.

**Pulmonary Rehabilitation**  
Medicare covers a comprehensive program of pulmonary rehabilitation if an individual has moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral for pulmonary rehabilitation from the doctor treating his chronic respiratory disease. These services are intended to help him breathe better, make him stronger and able to live more independently. These services may be provided in doctors’ offices or hospital outpatient setting that offer pulmonary rehabilitation programs.

An individual pays 20% of the Medicare-approved amount if he gets the service in a doctor’s office. He pays a copayment per session if he gets the service in a hospital outpatient setting.
### List of Services Covered By Medicare Parts A and B (Continued)

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<tr>
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<tbody>
<tr>
<td>Radiation Therapy</td>
<td>Medicare Part A covers radiation therapy for patients who are hospital inpatients. Medicare Part B covers it for outpatients or patients in freestanding clinics. An individual pays the inpatient deductible and coinsurance (if applicable). He pays a set copayment (for outpatient radiation therapy). He pays 20% of the Medicare-approved amount for radiation therapy at a freestanding facility.</td>
</tr>
</tbody>
</table>
| Religious Nonmedical Health Care Institution (RNHCI) | Medicare does not cover the religious portion of RNHCI care. Specifically, Medicare Part A covers inpatient nonreligious nonmedical care when the following conditions are met:  
  • The RNHCI has agreed and is currently certified to participate in Medicare.  
  • The Utilization Review Committee agrees that the individual would require hospital or skilled nursing facility care if it were not for his religious beliefs.  
  • The individual has a written election on file with Medicare indicating that his need for RNHCI care is based on his religious beliefs. The election must also indicate that if the patient decides to accept standard medical care, he will cancel the election and may have to wait one to five years to be eligible for a new election to get RNHCI services. Please note that an individual is always able to get medically necessary Medicare Part A services. In 2011, for each benefit period an individual pays the following:  
  • Days 1–60: $1,132 deductible.  
  • Days 61–90: $283 coinsurance each day.  
  • Days 91–150: $566 coinsurance each day.  
  • Beyond 150 days: all costs. |
| Respite Care (Inpatient)                     | Medicare Part A covers respite care (inpatient care given to a hospice patient so that the usual caregiver can rest) for hospice patients. See Hospice Care. An individual pays 5% of the Medicare-approved amount. |
| Rural Health Clinic and Federally Qualified Health Center Services | Medicare Part B covers a broad range of outpatient primary care services. An individual pays 20% of the Medicare-approved amount. |
| Second Surgical Opinions                     | Medicare Part B covers a second opinion in some cases for surgery that is not an emergency. A second opinion is when another doctor gives his view about an individual’s health problem and how it should be treated. Medicare will also help pay for a third opinion if the first and second opinions are different. An individual pays 20% of the Medicare-approved amount. |
| Shots (Vaccinations)                         | Medicare covers the following shots:  
  • Flu shot.  
  • Hepatitis B shot.  
  • Pneumococcal shot. |
| Skilled Nursing Facility (SNF) Care          | Medicare Part A covers skilled care in a skilled nursing facility (SNF) under certain conditions for a limited time. Skilled care is health care given when an individual needs skilled nursing or rehabilitation staff to manage, observe and evaluate his care. Medicare covers certain skilled care services that are needed daily on a short-term basis (up to 100 days). In 2011, an individual pays the following for each benefit period (following at least a related three-day covered hospital stay):  
  • Days 1–20: $0 each day.  
  • Days 21–100: up to $141.50 each day.  
  • Beyond 100 days: 100%. |
### List of Services Covered By Medicare Parts A and B (Continued)

<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td><strong>Skilled Nursing Facility (SNF) Care (cont.)</strong></td>
<td>There’s a limit of 100 days of Medicare Part A SNF coverage in each benefit period. Medicare will cover skilled nursing facility care if all these conditions are met: 1) An individual has Medicare Part A and has days left in his benefit period to use. 2) He has a qualifying hospital stay. This means an inpatient hospital stay of three consecutive days or more, including the day he is admitted to the hospital, but not including the day he leaves the hospital. 3) His doctor has decided that he needs daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If he is in the SNF for skilled rehabilitation services only, his care is considered daily care even if these therapy services are offered just five or six days a week, as long as he needs and gets the therapy services each day they are offered. 4) He gets these skilled services in a SNF that is certified by Medicare. 5) He needs these skilled services for a medical condition that was either of the following: a) A hospital-related medical condition (any condition that was treated during his qualifying three-day hospital stay, even if it was not the reason he was admitted to the hospital). b) A condition that started while he was getting care in the SNF for a hospital-related medical condition. For example, if while an individual is getting SNF care for a stroke that was also treated during his qualifying three-day hospital stay, he develops an infection that requires IV antibiotics, Medicare will cover his SNF care for treating the infection (as long as he also meet the conditions listed in items 1–4). While an individual is in a non-covered stay in the Medicare-certified part of the facility, his Part B therapy services (physical therapy, occupational therapy and speech-language pathology) must be billed by the facility. No other therapy service may be billed by another setting, such as an outpatient hospital setting. If he leaves the Medicare-certified part of the facility, his therapy services in the non-Medicare-certified part of the facility is limited by a specific dollar amount each year unless he gets the services from an outpatient hospital setting.</td>
</tr>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td>Medicare Part B covers up to eight face-to-face visits in a 12-month period if an individual is diagnosed with an illness caused or complicated by tobacco use, or if he takes a medicine that is affected by tobacco. An individual pays 20% of the Medicare-approved amount for the doctor’s services. In a hospital outpatient setting, he pays a copayment. An individual pays $0 for counseling sessions if he hasn’t been diagnosed with an illness caused or complicated by tobacco use.</td>
</tr>
<tr>
<td><strong>Speech-Language Pathology</strong></td>
<td>See Physical Therapy/Occupational Therapy/Speech-Language Pathology Services.</td>
</tr>
<tr>
<td><strong>Substance-Related Disorders</strong></td>
<td>Medicare covers treatment for substance-related disorders in inpatient or outpatient settings. Certain limits apply. See Mental Health Care.</td>
</tr>
<tr>
<td><strong>Supplies (uses in the home)</strong></td>
<td>Medicare Part B generally does not cover common medical supplies like bandages and gauze. Medicare covers some diabetes and dialysis supplies. See Diabetes Supplies and Services and Dialysis (Kidney) Services and Supplies. For items such as walkers, oxygen and wheelchairs, see Durable Medical Equipment (DME). An individual pays 100% for most common medical supplies he uses at home.</td>
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<td>Service</td>
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<tr>
<td>Surgical Dressing Services</td>
<td>Medicare Part B covers medically necessary treatment of a surgical or surgically treated wound. An individual pays 20% of the Medicare-approved amount for the doctor’s services. He pays a copayment for these services when he gets them in a hospital outpatient setting. He pays nothing for the supplies.</td>
</tr>
<tr>
<td>Telehealth</td>
<td>Medicare Part B covers certain telehealth services, such as office visits and consultations that are provided using an interactive two-way telecommunications system (such as real-time audio and video) by an eligible provider who is at a location different from the patient’s. Telehealth is available in some rural areas, under certain conditions, and only if the patient is located at one of the following places: a doctor’s office, hospital, rural health clinic, federally qualified health center, hospital-based dialysis facility, skilled nursing facility or community mental health center. An individual pays 20% of the Medicare-approved amount for the doctor’s services.</td>
</tr>
<tr>
<td>Therapeutic Shoes</td>
<td>See Therapeutic shoes or inserts under Diabetes Supplies and Services.</td>
</tr>
<tr>
<td>Transplants (Doctor Services)</td>
<td>Medicare Part B covers doctor services for transplants. See Transplants (Facility Charges). An individual pays 20% of the Medicare-approved amount for doctor services.</td>
</tr>
<tr>
<td>Transplants (Facility Charges)</td>
<td>Medicare Part A covers transplants of the heart, lung, kidney, pancreas, intestine and liver under certain conditions and only at Medicare-approved facilities. Medicare only approves facilities for kidney, heart, liver, lung, intestine and some pancreas transplants. Medicare Part B covers cornea and bone marrow transplants. Bone marrow and cornea transplants are not limited to approved facilities. Transplant coverage includes necessary tests, labs and exams before surgery. It also includes immunosuppressive drugs (under certain conditions), follow-up care for a patient and procurement of organs and tissues. Medicare pays for the costs for a living donor for a kidney transplant. An individual pays various amounts. For inpatient transplants, see Hospital Care (Inpatient).</td>
</tr>
<tr>
<td>Transportation (Routine)</td>
<td>Medicare doesn’t cover transportation to get routine health care. For more information, see Ambulance Services.</td>
</tr>
</tbody>
</table>
| Travel (health care needed when traveling outside the U.S.) | Medicare generally does not cover health care while an individual is traveling outside the United States. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands are considered part of the U.S. There are some exceptions. In some cases, Medicare Part B may pay for services that he gets while on board a ship within the territorial waters adjoining the land areas of the U.S. In rare cases, Medicare Part A may pay for inpatient hospital services that he receives in a foreign country under the following circumstances:  
  - He is in the U.S. when a medical emergency occurs, and the foreign hospital is closer than the nearest U.S. hospital that can treat the emergency.  
  - He is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.  
  - He lives in the U.S. and the foreign hospital is closer to his home than the nearest U.S. hospital that can treat his medical condition, regardless of whether an emergency exists.  
  Medicare also pays for doctor and ambulance services an individual receives in a foreign country as part of a covered inpatient hospital stay. An individual pays 20% of the Medicare-approved amount. |
<p>| Urgently Needed Care                | Medicare Part B covers this care to treat a sudden illness or injury that is not a medical emergency. An individual pays 20% of the Medicare-approved amount.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |</p>
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<tr>
<td>Walker/Wheel-chair</td>
<td>Medicare Part B covers power-operated vehicles (scooters), walkers and wheelchairs as durable medical equipment that a doctor prescribes for use in an individual’s home. For more information, see <em>Durable Medical Equipment (DME)</em>. <strong>Power wheelchair.</strong> An individual must have a face-to-face examination and a written prescription from a doctor or other treating provider before Medicare helps pay for a power wheelchair. An individual pays 20% of the Medicare-approved amount.</td>
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<tr>
<td>X-Rays</td>
<td>Medicare Part B covers medically necessary diagnostic x-rays that are ordered by an individual’s treating doctor. For more information, see <em>Diagnostic Tests, X-Rays and Clinical Laboratory Services</em>. An individual pays 20% of the Medicare-approved amount. In a hospital outpatient setting, he pays a copayment.</td>
</tr>
</tbody>
</table>
Testing Instructions for Examination for CPE Credit

Social Security and Medicare (DSMTG11)

1. Following these instructions is information regarding the location of the CPE CREDIT EXAMINATION QUESTIONS.

2. Log on to our Online Grading Center at cl.thomsonreuters.com/ogs. Click the purchase link and a list of exams will appear. Search for an exam by selecting Gear Up/Quickfinder in the drop-down box under Brand. Payment of $27 for the exam is accepted over a secure site using your credit card. Once you purchase an exam, you may take the exam three times. On the third unsuccessful attempt, the system will request another payment. Once you successfully score 70% on an exam, you may print your completion certificate from the site. The site will retain your exam completion history. If you lose your certificate, you may return to the site and reprint your certificate.

3. To receive CFP® credit, you must provide your name and CFP license number within the Online Grading Center. If Thomson Reuters does not receive your name and license number within 30 days of completion, the CFP Board will not award you credit.

4. Please direct any questions or comments to our Customer Service department at (800) 431-9025.
Examination for CPE Credit

To enhance your learning experience, examination questions are located immediately following each lesson. Each set of examination questions can be located on the page numbers listed below. The course is designed so the participant reads the course materials, answers a series of self-study questions, and evaluates progress by comparing answers to both the correct and incorrect answers and the reasons for each. At the end of each lesson, the participant then answers the examination questions and records answers to the examination questions by logging onto the Online Grading System. For more information on completing the Examination for CPE Credit, see the Testing Instructions on the preceding page.

### CPE Examination Questions

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