Successful Retired Planning Kit: What You Need to Know!

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I. INTRODUCTION

[Co-signature letter from NEA President and NEA Retired President.]
Retirement Checklist (check all that apply)

__ Pick a retirement date
- Pick a date that maximizes retirement income (birthday or anniversary of service).

__ Notify employer in advance, in writing.
- Ask your personnel or administrative department how much notice is needed for them to do retirement calculation and establish payment flow.

__ Select retirement payment and survivor options from retirement plan(s).
- There are usually several options available. These are important decisions and usually irrevocable once you begin retirement.

__ Plan for the conversion of medical and dental insurance after retirement.
- If you do not have coverage after retirement you will have to convert your current plans. Do NOT let coverage lapse.

__ Schedule major medical and dental work to be done prior to retirement.
- There may be a waiting period for pre existing conditions if you switch companies. Have the work done before you leave.

__ Determine amounts due from Social Security (self and spouse).
- Personal Employee Benefit Statement (PEBS) is available free. 1-800-772-1213.

__ Notify Social Security if 62 or older to begin payments (requires 4 months notice).

__ Sign up for Medicare (if 65).

__ Make or update your will and your spouse's will.
- Both you and spouse should have separate wills and instructions in the event of serious illness.

__ Review employer paid life insurance, which may be reduced upon retirement.
- Some term life insurance benefits are terminated at retirement.

__ Calculate how much income will be needed in retirement each month.
- 70 - 80% of pre-retirement income.

__ Make a list of monthly retirement cash inflow from all sources.
- Consider pensions, 403(b)'s, IRA's, 401(k)s, PT work, a business or sale of assets.

__ Determine how any shortfall of monthly income will be generated from investments or savings.

__ Discuss with accountant or financial advisor, best way to generate monthly income.

__ Decide on the payment option for any tax-deferred annuity.

__ Notify the company issuing the tax-deferred annuity of the chosen payment option.
Re-compute asset allocation investment plan for post-retirement risk tolerance and life expectancy.

Change investment mix to reflect revised asset allocation.

- Once you have determined the best asset mix, begin gradually shifting assets, say 6 months.

Calculate the effect of part-time work on Social Security payments.

Pay off credit card debt and other loans: consider paying off your house.

Consider long-term care insurance.
II. RETIREMENT PLANNING

Retirement Income Needs

People once believed that much less money was needed to live comfortably during their retirement years. This belief is rapidly giving way to the more realistic view that one needs nearly as much money after retirement as one did when working. The reason is that no one wants to lower the standard of living they've worked so hard to achieve. Nor do retired people want to become less active. In fact, most people want to continue with all the civic, social, travel, and other recreational activities that are such a big part of life right now. And that means one certainly doesn't want to retire without adequate income.

Inflation and increased medical expenses are factors that we can expect to continue to face during retirement, but we don't have to face them unprepared. Your Association believes it is important that you begin to assess your retirement income needs at an early age, and analyze the various sources of income available to meet them. Discrepancies between income needs and income sources can then be identified well in advance, in order to avoid retiring with inadequate income.

One investment option that is popular as a vehicle for the accumulation of retirement funds is the annuity. Annuities are contracts which can be purchased during the pre-retirement years from insurance companies to provide income for a specified period of time, usually after retirement.

Annuities are available to all persons, but the tax-deferred annuity is a special type of annuity that is only available to employees of certain institutions. Under Internal Revenue Code Sections 501(c)(3) and 403(b), employees of educational institutions and certain public institutions may reduce their income by permitting their employers to pay part of their earned income into an account where tax is deferred on the account until money is withdrawn, usually after retirement.

"Tax-deferred" means that payment of federal and many times state taxes on the portion of annual salary invested in an annuity can be delayed or "deferred," until such funds are received from the annuity by the annuitant or a beneficiary. Taxes are also deferred on the interest earned by the investment. For those not eligible to participate in a tax-deferred annuity investment under 501(c)(3) and 403(b), only the interest earned on the principal is tax-deferred until withdrawn; taxes must be paid on the principal. The purpose of this guide is to help you understand these popular products so that you can evaluate TDAs offered by different companies and make an informed decision regarding participation.

Source of Income During Retirement

Few people realize just how much money they will need to provide a monthly income for life. There are many possible sources of income for your retirement years. Some may involve government programs. Others may depend primarily on private insurance annuities, employer pensions, etc. Some give you tax advantages, while others do not. The following is a brief outline of these sources:

1. Social Security retirement benefits
2. Private retirement plans
   a. Employer-provided pension plans
   b. Retirement plans for the self-employed (Keogh plans)
   c. Individual retirement accounts (IRA plans)
   d. Employer-funded savings under Section 457
   e. Tax-deferred annuities under Section 403(b)
   f. 401(k)
   g. Thrift Plans

3. Life insurance with cash values

4. Investments and other privately owned assets (such as the equity in your home, mutual funds, stocks and bonds, and personal savings accounts)

PRIVATE RETIREMENT PLANS

Private savings arrangements can run the gamut from bank savings accounts to stock mutual funds to gold coins. The common feature in these arrangements is that the contributions are invested after taxes have been paid on them (i.e., after-tax contributions). Investment earnings may or may not be tax-deferred. There are no restrictions on withdrawals, other than those that may be imposed by the issuer of the investment.

Employer-Provided Pension Plans

Another major source of retirement income can be a formal retirement plan established by your employer. Benefits vary considerably from plan to plan, but they're often based on the number of years of service and your salary level at retirement. Your plan has an administrator who can help you estimate what you can expect to receive from this source.

Retirement plans can be classified as either "defined contribution" or "defined benefit." A defined contribution plan lets you contribute a set amount each year that may not exceed a calculated amount. A defined benefit plan, the more common type, determines benefits to be paid, based on set standards such as length of service or other established criteria. Simply put, with a defined benefit plan, the amount of plan funding is determined by the amount of benefits the plan is designed to pay.

Pension Plans

Pension plans are often funded in total by the board of education or state. However, for some plans, employee contributions are required for participation in the plan or to receive increased plan benefits. Contributions to a pension plan are sometimes made on an after-tax basis. However, for the person who stays with a school system until fully vested in his/her pension benefits, the pension plan usually provides substantially greater benefits than the individual could obtain by investing his/her contributions outside the plan.

Individual-Retirement Accounts
Since its initial introduction in 1975, few investment opportunities have helped more people prepare for retirement than the Individual Retirement Account (IRA). There are currently two different kinds of IRA designed for retirement planning; the Traditional IRA and the Roth IRA. Deciding which one is best for you depends on your own unique set of circumstances. The first step is to determine your eligibility for the different IRAs, and then the suitability of each to your retirement plan. To find out your eligibility, take this short quiz.

The Traditional (deductible) IRA
1. Are you under age 70½?
2. Do you have earned income?

If you answered "yes" to both of these questions and do not participate in an employer-sponsored plan, you are eligible to start contributing to a Traditional IRA today. Even if you do participate in an employer plan, you may still be eligible. It's a good idea to check with a financial professional to get all the details.

The Roth IRA
1. Do you have earned income?
2. Are you single with an Adjusted Gross Income (AGI) below $105,000, OR married with a joint AGI below $167,000 (2010 tax year)? [Check the NEA Retired website for updated information.]

If you answered "yes" to both of these questions you are eligible to start contributing to a Roth IRA.

Determining which IRA is best for you
You may well be eligible for either IRA, so it's a good idea to look at the benefits each offers to determine which IRA best suits your retirement goals. Depending on your circumstances, contributions to a Traditional IRA may be tax deductible and the earnings grow tax-deferred. When distributions are taken from the IRA, however, they are taxable.

On the other hand, contributions to a Roth IRA are never tax deductible, but distributions are completely tax-free if the Roth IRA has been held for five years and the account owner has either attained age 59½, died, become disabled or used the proceeds up to $10,000 (lifetime maximum) for a "first time" home purchase.

IRC Section 403(b) Tax-Sheltered Annuities (TSAs)
An IRC 403(b) Tax-Sheltered Annuity (TSA) is a retirement plan for nonprofit organizations such as schools, hospitals or social service agencies. These plans allow you to set aside a portion of your pay before taxes (up to $16,500 a year). [Check the NEA Retired website for updated information.] The money invested in a TSA grows free from taxation until such time as you withdraw the money.

Withdrawing money from your 403(b) plan before age 59½ is generally prohibited. But there are exceptions (hardship, purchase of a primary residence, or college tuition).
you qualify for a hardship withdrawal, you will still pay a 10% early withdrawal penalty plus regular income taxes.

Employees can participate in a 403(b)(7) mutual fund program (if available). The performance of these qualified mutual funds appears to closely follow the performance of their respective non-qualified mutual fund counterparts. There are a number of good mutual fund surveys that evaluate the historical performance of these types of funds and their related expenses. Mutual funds are a common investment, however, unlike the fixed insurance contract there are no guarantees of return. Investments that mirror the qualified mutual fund earnings can also be incorporated in a TDA product to provide additional flexibility and investment options to a participant.

**IRC Section 457 Plans**

Section 457 Deferred Compensation plans are becoming more popular in this decade, but are still not found as frequently as access to a tax-sheltered annuity. Eligible sponsors of a 457 Plan are state and local governments, semi-governmental agencies or any tax-exempt organization under the Internal Revenue Code.

Under Section 457, employees may make a salary reduction agreement with the employer. The reduction amount is then contributed by the employer to the plan. Employee contributions, called elective deferrals can also be made to the plan. Elective deferrals are not includable in the employee’s gross income at the time the contributions are made. However, they will be includable in gross income later when the employee or beneficiary receives them.

Employees may not make loans under a 457 plan. This is because the funds in the Plan are always subject to the general business creditors of the employer. Employees cannot have access to the funds in the form of a loan as the funds are subject to levying. However, premature distributions from a 457 plan are not subject to the 10% penalty tax to which other qualified plans are subject if funds are withdrawn prior to age 59½.

**401(k) Plans**

An Internal Revenue Code (IRC) 401(k) is a retirement savings plan to which you can contribute a certain percentage of your gross income. However, contributions to a 401(k) and certain other qualified deferred compensation arrangements cannot exceed an annual limit. Typically with a 401(k) plan you have several investment options from which to choose, including stocks, bonds, mutual funds or CDs.

**Keogh (HR-10) Plan**

A Keogh plan is a qualified retirement plan established by the Self Employed Individuals Tax Retirement Act of 1962, otherwise known as the Keogh Act, or HR-10. Keogh plans may be set up by self-employed persons, partnerships, and owners of unincorporated businesses as either a defined benefit or defined contribution plan. As defined contribution plans, they may be structured as a profit sharing, a money purchase, or a combined profit sharing/money purchase plan.

**CATCH-UP AMOUNTS**
Plans may permit one or both of the following catch-up provisions. Note: Catch-up contributions must be applied first to the years-of-service catch-up limits (for employees with 15 years of service) before being applied to the Age-50 catch-up.

Years of Service Catch-Up — this catch-up is available through certain employers. Limited to the least of:
- $3,000
- $15,000 less previously excluded special catch-ups
- $5,000 multiplied by years of service minus previously excluded deferrals

Age-50 Catch-Up — this $5,500 per year catch-up is available for any participant who has attained age 50 or more by December 31st. This catch-up cannot exceed the employee’s includible compensation.

[Check the NEA Retired website for updated information.]
## Overview of Retirement Programs (2010)

<table>
<thead>
<tr>
<th></th>
<th>Section 403(b) Plan</th>
<th>Section 457 Plan</th>
<th>Deductible IRA</th>
<th>Roth IRA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>Employees of educational institutions and certain public institutions with an employer-sponsored 403(b) plan.</td>
<td>Employees of educational institutions and certain public institutions with an employer-sponsored 457 plan.</td>
<td>People who do not take part in employer retirement plans, regardless of income; or people with such plans if their 2010 AGI is under a certain limit (joint filers = $89,000; single filers = $56,000).</td>
<td>Joint filers whose AGI is less than $167,000. Single filers whose AGI is less than $105,000.</td>
</tr>
<tr>
<td><strong>Contributions</strong></td>
<td>Contributions and earnings are not taxed until withdrawal.</td>
<td>Contributions and earnings are not taxed until withdrawal.</td>
<td>Contributions and earnings are not taxed until withdrawal.</td>
<td>Qualified distributions are not taxed upon withdrawal.</td>
</tr>
<tr>
<td><strong>Contribution Limitation (annual)</strong></td>
<td>$16,500</td>
<td>$16,500</td>
<td>$5,000 For all IRA’s (except Education IRA) combined.</td>
<td>$5,000 For all IRA’s (except Education IRA) combined.</td>
</tr>
<tr>
<td><strong>Catch-Up Contributions Age 50+</strong></td>
<td>$5,500</td>
<td>$5,500</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Loans</strong></td>
<td>Available</td>
<td>Not available.</td>
<td>Not available.</td>
<td>Not available.</td>
</tr>
<tr>
<td><strong>Investments</strong></td>
<td>Annuities; mutual funds through a 403(b)(7).</td>
<td>Annuities and mutual funds.</td>
<td>Primarily mutual funds.</td>
<td>Primarily mutual funds.</td>
</tr>
<tr>
<td><strong>Distributions</strong></td>
<td>Distributions before age 59½ are subject to a 10% penalty; certain exceptions apply.</td>
<td>Distributions before age 59½ are not subject to any penalties.</td>
<td>Distributions before age 59½ are generally subject to a 10% penalty.</td>
<td>Distributions before age 59½ are generally subject to a 10% penalty.</td>
</tr>
<tr>
<td><strong>Federal Taxes Waived</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>If the money is invested for five years and after age 59½, earnings will be free of federal income tax.</td>
</tr>
</tbody>
</table>
PERSONAL SAVING ACCOUNTS

Most retirees hold more cash in bank accounts due to the safety of the deposits (e.g., they will not lose money like the stock market). The most common type offered by credit unions or banks are certificate of deposits, money market accounts, and passbook savings accounts. All are generally insured up to $250,000 by the Federal Deposit Investment Corporation (FDIC) for all deposits at one institution. [Check the NEA Retired website for updated information.]

Certificate of Deposit

A certificate of deposit (CD) is a special type of deposit account with a bank or savings institution that typically offers higher rates of interest than a regular savings account. Unlike other investments, CDs are protected by federal deposit insurance up to $250,000. [Check the NEA Retired website for updated information.]

When you purchase a CD, you invest a fixed sum of money for a fixed period of time – six months, one year, five years, or more – and, in exchange, the issuing bank pays you interest, typically at regular intervals. When you cash in or redeem your CD, you receive the money you originally invested plus any accrued interest. But if you redeem your CD before it matures, you may have to pay an "early withdrawal" penalty or forfeit a portion of the interest you earned.

Although most investors have traditionally purchased CDs through local or national banks, many brokerage firms and independent salespeople now offer CDs. These individuals and entities – known as "deposit brokers" – can sometimes negotiate a higher rate of interest for a CD by promising to bring a certain amount of deposits to the institution. The deposit broker can then offer these "brokered CDs" to their customers.

At one time, most CDs paid a fixed interest rate until they reached maturity. But, like many other products in today's markets, CDs have become more complicated. Investors may now choose among variable rate CDs, long-term CDs, and CDs with other special features.

Some long-term, high-yield CDs have "call" features, meaning that the issuing bank may choose to terminate – or call – the CD after only one year or some other fixed period of time. Only the issuing bank may call a CD, not the investor. For example, a bank might decide to call its high-yield CDs if interest rates fall. But if you've invested in a long-term CD and interest rates subsequently rise, you'll be locked in at the lower rate. Be very careful of these types of CD's because they usually have long-term periods (excess of 10 years).

Before you consider purchasing a CD from your bank or brokerage firm, make sure you fully understand all of its terms. Carefully read the disclosure statements, including any fine print, and ask questions.

Money Market Accounts

These accounts, offered by a bank or credit union, usually earn slightly higher interest than a savings account, but still allow easy access to your money. Some banks and financial institutions require an initial deposit of $1,000 or more and limit the number of withdrawals or transfers you can make during a given period of time.
Money market accounts are a good place to hold money for emergencies (i.e., loss of job, water heater/air conditioner breaks, auto accident, etc.). Instead of relying on credit cards, many individuals and families save between three to six months of their expenses in an account. If the money is held in an account separate from checking, then you will not have the inclination to spend it. Money market accounts are also a good place to hold money that will be needed in the short term – like money you are setting aside to be used for a house down payment.

**Passbook Saving Accounts**

How do CDs and money market accounts differ from "passbook" savings accounts? Essentially the differences are the interest rate and the accessibility of your money. Since the savings account holder can withdraw money at any time, the interest rate provided is very low. CDs and money market accounts limit the "fluidity" of money, which in turn allows the bank to hold the money longer and thus provide a higher interest rate.
BEGINNING YOUR RETIREMENT

Don't assume that by reaching a magic age, your retirement checks will start arriving from your employer sponsored pension plan. They may, or they may not. Often you will need to notify your employer formally of your intention to retire several months in advance. When you do, you will usually be faced with a number of retirement options concerning payments, survivor options, etc. Decisions made about your retirement options are often not reversible, and you may need to seek help from a qualified tax advisor or financial planner specializing in these matters.

How to Withdraw from Retirement Accounts

As a general rule, you should withdraw money from taxable accounts first, so that assets held in IRAs and other qualified retirement accounts can grow tax-deferred as long as possible. (In some cases, however, there may be valid estate planning reasons not to follow this rule; consult with your estate planning and tax advisors on this issue.)

If you have to make withdrawals from your tax-deferred accounts before you turn 59½, you will probably have to pay the IRS a 10 percent early withdrawal penalty. (There are exceptions: see your tax person or financial advisor). Once you reach age 70½, you will encounter an opposite problem: hefty tax penalties for withdrawing too little from your tax-deferred accounts. In the case of IRAs, this penalty is 50 percent of the amount you should have taken but didn't. (In the case of 403(b) accounts, however, minimum withdrawal requirements kick in at the later of 70½ or when you actually retire.)

The penalties represent Congress's desire to balance competing priorities and policy goals. Tax-deferred retirement accounts were invented because lawmakers wanted to encourage individual Americans to save more for retirement. On the other hand, these accounts cost the federal government substantial tax revenue. The 70½ rule is structured to prevent people from squirreling away tax-deferred money indefinitely.

How long will your money last?

The table on the next page is useful in determining how long your retirement savings will last at different rates of annual earnings and annual withdrawals.

The top row is the estimated average annual return on your retirement savings. The left column is the annual withdrawal rate of your retirement savings. The middle columns and rows represent the number of years your retirement savings will last. Of course, you will add the withdrawal amounts to any pensions, Social Security and other income during retirement to get the whole picture for your situation.
<table>
<thead>
<tr>
<th>Annual withdraw rate</th>
<th>4%</th>
<th>5%</th>
<th>6%</th>
<th>7%</th>
<th>8%</th>
<th>9%</th>
<th>10%</th>
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<td>15%</td>
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For example, if your retirement nest egg is $200,000 and you need $20,000 from it each year to augment your pension and Social Security that is an annual withdrawal rate of 10 percent. If your nest egg grows each year on average by 7 percent, the $200,000 will last you 17 years. If you want it to last longer, say 30 years, you'll have to cut your withdrawal rate down to 8 percent or $16,000 per year.

**Managing Savings During Retirement**

When you retire you will have income from your retirement plan, and perhaps Social Security. This may satisfy anywhere from 50 to 70 percent of your monthly needs. Social Security is currently indexed annually for inflation. Your pension may or may not be indexed: many pensions are fixed amounts that never go up. The balance of your monthly needs will have to come from your investments. So you will probably need to keep your retirement investments working for you. There are several main points to consider: safety, liquidity and growth.

**Safety.** When you are retired, the last thing you want to do is invest your money in high-risk securities or get-rich-quick ventures. Be careful. There is a cottage industry of folks who would like to sell you "hot" investments: often over the phone. These telephone sales people target seniors. They buy your name and number from list brokers, and while they don't know that much about you when they call, they try
convincingly to extract a lot of personal financial information from you early in the conversation. The best strategy to deal with these people is to quickly terminate the conversation and under no circumstances provide them personal or financial information.

With that out of the way, how do you hang on to your hard-earned retirement assets? Chances are when you consider your age and your tolerance for risk, your profile will indicate that you should be a more conservative investor. For example, shift to more equity income type funds, bond funds, and cash equivalent funds (like money market funds). It may take you awhile to rearrange your investments to match your new profile, but in the end, when you do, you should be at considerably less risk to losses from market fluctuations than you were when you were in an asset accumulation phase.

**Liquidity.** Liquidity means the ability to convert your retirement assets to cash quickly. The most liquid investments are cash in banks and money market funds. CD's have a term varying from 3 months to 5 years, and while you can get at your money sooner, you may pay a significant penalty for "early withdrawal". Many other investments are liquid in the sense that stocks, bonds, mutual funds, and annuities can be sold or redeemed and the money is in your hands usually in a matter of days. Investments that are not very liquid include: residential or income property, limited partnerships, and the sale of a business interest.

**Growth.** Until recently, a rule of thumb about the proportions of fixed income investments to stocks or stock funds was to first subtract your age from 100, and apply the larger number to bonds (fixed income investments) and the smaller number to stocks or stock oriented mutual funds. For example, at 62 you should have only 38 percent of your assets in stocks and 62 percent in bonds or other fixed income. There is a reason why the experts are moving away from this thinking. People are living a lot longer, and while this rule of thumb is good for "preservation of capital", it is not so good for achieving "growth of capital" -- something you might need to do to provide income over a long retirement horizon. You can't do much about Social Security or your pension in terms of generating more income, but you can take a slightly more aggressive approach to investing your retirement assets, if you are comfortable doing so.
**Social Security**

**How to sign up for Social Security**

Notify the Social Security Administration. The Social Security Administration advises people to apply for retirement benefits four months before they want the benefit to begin. Important: even if you have no plan to receive benefits because you plan to continue working, you should still sign-up for Medicare four months before age 65. You can apply for retirement or Medicare benefits by calling 1-800-772-1213. Or you can visit your local Social Security Office (a list of offices can be found on the web at [www.ssa.gov](http://www.ssa.gov)).

When you apply for benefits you will need the following information:

- your Social Security number
- your birth certificate or other evidence of your date of birth
- your W-2 forms or self-employment tax return for last year
- your military discharge papers if applicable
- your mother's maiden name
- your spouse's birth certificate and Social Security number if he/she is also applying for benefits
- your checking or savings account information, so your benefits can be directly deposited to your account each month.

Any person who is eligible for Social Security can begin receiving benefits at age 62. However the benefits are reduced for each month under the age when full benefits begin. Visit the Social Security web site for further details at [www.ssa.gov/retire2/retirechart.htm](http://www.ssa.gov/retire2/retirechart.htm). If you do not need the income from Social Security right away, you can get a larger payment by waiting until after your full retirement age. Starting your payments after your full retirement age will increase your benefits by a formula that depends on your year of birth (be sure to contact the Social Security Administration). If you do defer payments you should still sign up for Medicare at age 65!

**How much can I expect to get in Social Security benefits?**

The amount of benefits to which you are entitled under the Social Security program is based on the income you have earned through your years of working. In most jobs, both you and your employer have paid Social Security taxes on the amounts you earned. Since 1951, Social Security taxes have also been paid on reported self-employment income. Social Security keeps a record of these earnings over your working lifetime, and pays benefits based on the average amount earned.

**How much can I expect to get in Social Security benefits?**

The amount of benefits to which you are entitled under any Social Security program (except SSI -- Supplemental Security Income) is not related to need, but is based on the income you have earned through years of working (through jobs and self-employment). Social Security keeps a record of these earnings over your working lifetime, and pays...
benefits based on the average amount earned. The Social Security calculator can be found at www.ssa.gov/planners/benefitcalculators.htm.

Who is eligible to collect Social Security benefits?

The specific requirements vary depending on the type of benefits, the age of the person filing the claim, and, if you are claiming as a dependent or survivor, the age of the worker.

There is one general requirement, however: the worker on whose earnings record the benefit is to be paid must have worked in "covered employment" for a sufficient number of years -- that is, earned enough of what Social Security calls work credits -- by the time he or she claims retirement benefits, becomes disabled, or dies. This usually means a total of at least ten years of work.

Note that Social Security has separate eligibility rules for some specific types of workers, including:

- federal, state, and local government workers
- workers for nonprofit organizations
- members of the military
- household workers, and
- farm workers.

If you have been employed for some time as one of these types of workers, check with the Social Security Administration for the rules that may affect your eligibility.

When can I start collecting Social Security retirement benefits?

The Social Security Administration used to consider 65 to be full retirement age for the retirement benefit. Benefits amounts were calculated on the assumption that most workers will stop working full time and will claim retirement benefits when they reach age 65.

Now that people are generally living longer, however, the Social Security rules for what is considered full retirement age are changing. Age 65 is still considered full retirement age for anyone born before 1938. However, full retirement age gradually increases from age 65 to 67 for people born in 1938 or later. For anyone born after 1960, the full retirement age is 67.

### Retirement Age for Those Born After 1937

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<thead>
<tr>
<th>Year Born</th>
<th>Full Retirement Age</th>
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<tr>
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<td>65 years, 2 months</td>
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<tr>
<td>1939</td>
<td>65 years, 4 months</td>
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<tr>
<td>1940</td>
<td>65 years, 6 months</td>
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The system does provide for early retirement at age 62, but also offers higher benefits for people who wait to make their claims after reaching full retirement age.

**How are my Social Security benefit amounts calculated?**

The calculations are complicated. The amount of any benefit is determined by a formula based on the average of your yearly reported earnings since you began working.

But to complicate matters, Social Security computes your average earnings differently depending on your age. If you reached age 62 or became disabled on or before December 31, 1978, Social Security averages the actual dollar value of your total past earnings -- and bases the amount of your monthly benefits on that amount.

If you turn 62 or become disabled on or after January 1, 1979, Social Security divides your earnings into two categories: Earnings from before 1951 are credited with their actual dollar amount, up to a maximum of $3,000 per year; and from 1951 on, yearly limits are placed on earnings credits, no matter how much you actually earned in those years.

**Can I keep a job even after I start collecting retirement, dependents, or survivors benefits?**

Yes, and many people do just that. People who are past full retirement age may work and earn any amount without losing any of their Social Security benefits.

However, people who collect Social Security before the year in which they reach full retirement age will lose one dollar of those benefits for every two dollars they earn over a set yearly limit. For the year 2010, that limit is $14,160. [Check the NEA Retired website for updated information.] The limit applies only to earnings from work; it does not apply to income from such things as savings, investments, pensions, or rental property. In other words, earnings from these sources will not affect your Social Security benefits.
The Social Security Administration has added a special twist for the year in which you reach full retirement age. During the months of that year that are prior to your birthday, you will lose one dollar of benefits for every three dollars you earn over a set yearly limit. For the year 2010, that limit is $37,680 (counting only earnings from the months prior to your birthday). [Check the NEA Retired website for updated information.] After your birthday, you can earn any amount of money without losing benefits.

**Can I collect more than one type of benefit at a time?**

No. You may qualify for more than one type of Social Security benefit at a time, but you can collect just one. For example, you might be eligible for both retirement and disability, or you might be entitled to benefits based on your own retirement as well as on that of your retired spouse. You can collect whichever one of these benefits is higher, but not both.

**Can I claim spousal benefits if I'm divorced?**

You are eligible for dependents benefits if both you and your former spouse have reached age 62, your marriage lasted at least ten years, and you have been divorced for at least two years. This two-year waiting period does not apply if your former spouse was already collecting retirement benefits before the divorce.

You can collect benefits as soon as your former spouse is eligible for retirement benefits. He or she does not actually have to be collecting those benefits for you to collect your dependents benefits.

If you are collecting dependents benefits on your former spouse’s work record and then marry someone else, you lose your right to those benefits. You may, however, be eligible to collect dependents benefits based on your new spouse’s work record. If you divorce again, you can return to collecting benefits on your first spouse’s record, or on your second spouse’s record if you were married for at least ten years the second time around.

**Types of Social Security Benefits: Retirement, Disability, Dependents, and Survivors**

A breakdown of the various Social Security benefits and how they are paid. Four basic categories of Social Security benefits are paid based upon the record of your earnings: retirement, disability, dependents, and survivors benefits.

**Retirement Benefits**

Workers who have worked in “covered employment” for a sufficient number of years are eligible for retirement benefits when they retire at age 62. This usually means you must have worked a total of at least ten years of work at a nongovernmental job.

You may choose to begin receiving retirement benefits at any time after you reach age 62. However, there are incentives to wait until your “full retirement age,” which is between 65 and 67, depending on the year of your birth. The amount of your benefits will be permanently reduced by a certain percentage if you begin claiming them before you reach full retirement age. As a further incentive to keep working, the amount of your benefits will be slightly, but permanently, increased for each year you wait until age...
70 to put in your claim. But no matter how long you wait to begin collecting benefits, the amount you receive will probably be only a small percentage of what you were earning.

Disability Benefits

If you haven't reached retirement age but have met the work requirements and are considered disabled under the Social Security program's medical guidelines, you can receive benefits roughly equal to what your full retirement benefits would be.

Dependents Benefits

If you are the spouse of a retired or disabled worker who qualifies for Social Security retirement or disability benefits, you and your minor or disabled children may be entitled to benefits based on the worker's earning record. This is true whether or not you actually depend on your spouse for your support.

Survivors Benefits

If you are the surviving spouse of a worker who qualified for Social Security retirement or disability benefits, you and your minor or disabled children may be entitled to benefits based on your deceased spouse's earnings record.

Checking Your Social Security Earnings and Benefits

Find out your estimated Social Security benefits at retirement age (and whether you'll qualify).

The Social Security Administration (SSA) keeps a running computer account of your earnings record and work credits, tracking both through your Social Security number. The administration mails out this information annually on Social Security statements to everyone age 40 (who is not already receiving Social Security benefits). The Social Security statement gives you an estimate of the benefits you'll receive at retirement age, which can play an important role in your financial planning.

How to Get a Copy of Your Social Security Statement

If you are age 40 or over and have not received your statement, or if you want to check your statement before you're 40, you can request a copy by following the instructions on the SSA website at www.ssa.gov. If you would prefer to make the request in writing, you may fill out a simple form, SSA 7004, called a Request for Social Security Statement, available at your local Social Security office or by calling 800-772-1213.

Check the Social Security Administration's Math

It is always wise for you to check the SSA's work. Don't be surprised if you uncover an error. Some government-watchers estimate that the SSA makes mistakes on at least 3% of the total official earnings records it keeps. When you check your record, make sure that the Social Security number noted on your earnings statement is your own, and make sure the earned income amounts listed on the agency's records mesh with your own records of earnings as listed on your income tax forms or pay stubs.
How to Correct an Error on Your Social Security Statement

If you have evidence of your covered earnings in the year or years for which you think Social Security has made an error, call Social Security's helpline at 800-772-1213, Monday through Friday, from 7 a.m. to 7 p.m. This is the line that takes all kinds of Social Security questions, and it is often swamped, so be patient. It is best to call early in the morning or late in the afternoon, late in the week, or late in the month. Have all your documents handy when you speak with a representative.

If you would rather speak with someone in person, call your local Social Security office and make an appointment to see someone there, or drop into the office during regular business hours. If you drop in, be prepared to wait, perhaps as long as an hour or two, before you get to see a representative. Bring with you two copies of your benefits statement and the evidence that supports your claim of higher income. That way, you can leave one copy with the Social Security worker. Write down the name of the person with whom you speak so that you can reach the same person when you follow up.

The process to correct errors is slow. It may take several months to have the changes made in your record. After Social Security confirms that it has corrected your record, request another benefits statement to make sure the correct information made it to your file.
Reverse Mortgages

Applying for reverse mortgages is one of the fastest-growing trends in America. Reverse mortgages are a special type of home loan that lets a homeowner convert the equity in his/her home into cash. They can give older Americans greater financial resources to supplement Social Security, meet unexpected medical expenses, make home improvements, and more.

Designed for seniors, a reverse mortgage is a loan that allows the homeowner to convert some of the equity in his/her home into cash or monthly income, while retaining home ownership. Reverse mortgages work much like traditional mortgages, only in reverse. Rather than making a payment to the lender each month, the lender pays the borrower.

To qualify for a reverse mortgage, all persons on the title must be at least 62 years old and must occupy the home as their principal residence. The applicant must own the home “free and clear” or have a very small mortgage balance. The reverse mortgage funds may be paid in a lump sum, in monthly advances, through a line-of-credit, or in a combination of the three, depending on the type of reverse mortgage and the lender.

Because the individual retains title to the home with a reverse mortgage, s/he also remains responsible for taxes, repairs, and maintenance. Depending on the plan selected, the reverse mortgage becomes due with interest either when the homeowner permanently moves, sells the home, or dies. The lender does not take title to the home when the homeowner dies, but the heirs must pay off the loan. The debt is usually repaid by refinancing the loan into a new “forward” mortgage (if the heirs are eligible) or by using the proceeds from the sale of the home.

The costs associated with a reverse mortgage are very much like those for a traditional mortgage. There is a loan origination fee, the cost of a property appraisal and credit report, an FHA mortgage insurance premium, and various other costs. All costs except for $300 of the loan origination fee can be financed into the loan.

Counseling for the homeowner is required before a lender can accept a reverse mortgage application. Homeowners who are interested in a reverse mortgage will be put in touch with a reverse mortgage counselor in their area. This free counseling service can help seniors decide whether a reverse mortgage is appropriate for them.
Bankruptcy

In the context of this article on personal bankruptcies, bankruptcy is a legal procedure that serves as a "last resort" for people who cannot pay their debts. There are two types of bankruptcy filing available to most individuals:

- **Chapter 7** involves liquidation of all non-exempt assets (usually sold by a court-appointed official or turned over to creditors) and the discharge of debts for exempt assets. (What is considered exempt and non-exempt varies between the federal and state governments, and state regulations may prevail over the federal. Consult [www.bankruptcyaction.com](http://www.bankruptcyaction.com) under the heading “Bankruptcy Exemptions” in the right-hand column for information on exempt and non-exempt assets by state.)

- **Chapter 13** allows debtors to discharge certain debts but pay off or cure default over a period of three to five years rather than surrender other property.

Bankruptcy usually does not discharge obligations such as child support, alimony, fines, taxes, and some student loans.

**Bankruptcy Abuse Prevention and Consumer Protection Act of 2005**

Contrary to popular misconception, the majority of those who declare bankruptcy have not abused credit cards. Most people file bankruptcy because they have experienced one of the following difficult life circumstances: a serious illness (of either themselves or another person who earns income for the household), the loss of a job, or divorce. Unfortunately, the new law doesn't give any special consideration to individuals who file for these reasons.

The law:

- Includes a "means test" by which the IRS determines who can legitimately file for bankruptcy and who cannot. Those with lower income may file a Chapter 7 bankruptcy, which, if approved by a judge, erases debts entirely after certain assets are forfeited. Those with income above their state's median income who can pay at least $6,000 over five years ($100 a month) would be forced to file Chapter 13, where a judge would then order a repayment plan.

- Requires that people filing for bankruptcy pay for credit counseling.

- Has a provision that gives top priority to a spouse's claims for child support among creditors' claims on a debtor in bankruptcy.

- Restricts a state's homestead exemption to $125,000 if the person in bankruptcy bought his or her residence less than three years and four months before filing. [Florida, Iowa, Kansas, South Dakota, and Texas have unlimited homestead exemptions that enable wealthy people to file for bankruptcy while keeping their mansions sheltered from creditors.]

- Places the burden of proof for bankruptcy on the debtor's lawyer, requiring the attorney's signature on the petition and verification that they have investigated the claim sufficiently and found it to be solid. While this may be a necessary step to ensure that claims are valid, it will also take more time and increase legal bills.
- Broadens the definition of "nondischargeable" debts (meaning debts that can't be erased through Chapter 7 filing) to include certain types of student loans, debts to state and local governments, and monies owed to "governmental units."

**Bottom Line**

Most filers currently pay a $299 court filing fee and $500 to $1,500 for an attorney to represent them in the simplest cases filed under Chapter 7 of the bankruptcy code. [Check the NEA Retired website for updated information.] The filing fee will rise and attorney fees will increase 30 percent to 40 percent because of the extra paperwork required. The bottom line is that bankruptcy is going to be a lot more difficult and expensive.

People who file for bankruptcy often do so under the misconceived notion that it is a quick solution to their problems. However, bankruptcy does not erase a bad credit record, and the bankruptcy itself is likely to remain a part of the credit record for up to ten years. In actuality, it is likely to make the credit report appear even worse to most creditors.

**A Special Note About Individual Retirement Accounts (IRAs) and Bankruptcy**

The Supreme Court ruled unanimously on April 5, 2005, that Individual Retirement Accounts (IRAs) are to be shielded from the reach of creditors in bankruptcy proceedings. The justices said that IRAs fall under a provision of the U.S. Bankruptcy Code that exempts payments a debtor receives “on account of age,” such as pensions and annuities, when they are necessary to support the debtor.

The ruling clears up a split between some lower courts over whether IRAs can be protected from creditors. It puts IRAs in the same category as pensions and annuities, which are exempt from seizure under federal bankruptcy law. Most states prevent the seizure of IRA funds.
III. INSURANCE

MEDICARE

Medicare is an entitlement program funded primarily by payroll taxes. Age and work history determine eligibility. U.S. citizens 65 years and older qualify for Medicare coverage. Many other residents also qualify, although non-citizen eligibility rules have been tightened in recent years.

Medicare serves over 44 million beneficiaries at an annual cost exceeding $431 billion in 2007, according to the Centers for Medicare & Medicaid Services, the agency responsible for administering both Medicare and Medicaid.

There are currently four parts to Medicare coverage.

- Part A is known as Hospital Insurance and is free to people at age 65 and older who have contributed to the Federal Insurance Contribution Act (FICA) over their working years. Those covered by Medicare Part A insurance must pay an initial amount towards their hospital bill before Medicare coverage kicks in. This amount, known as the hospital deductible, rises every January 1.

- Part B has much simpler eligibility requirements. Part B is insurance that pays for Basic Medical Services provided by physicians, clinics and laboratories after a deductible that rises each January 1. Part B is not free; participants pay a monthly premium that rises every January 1.

- Part C, known as "Medicare Advantage," is an option that can replace Parts A and B.

- Part D is the Medicare Prescription Drug Plan.

Medicare by no means pays for all medical-related expenses. It usually covers only about half of such costs. For this reason, many of those eligible for Medicare have chosen to purchase supplemental coverage, also known as "Medicare Supplement" (or Medigap) insurance. Such policies pay for many medical-related expenses that are not reimbursed by Medicare.

Medicare Hospital Insurance Benefits (Part A)

Medicare Part A helps pay for medically necessary inpatient care in a hospital, inpatient acute care in a skilled nursing facility, or inpatient care in a psychiatric hospital; for hospice care; for medically necessary home health care; and for wheelchairs, hospital beds, and other durable medical equipment supplied under a home health care benefit.

Benefit Periods

Medicare Part A hospital and skilled nursing facility benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive a Medicare-covered service in a qualified hospital. It ends when you have been out of a hospital, or skilled nursing or rehabilitation facility for 60 days in a row. It also ends if you remain in a skilled nursing facility but do not receive any skilled care there for 60 days in a row.

If you enter a hospital again after 60 days, a new benefit period begins. With each new benefit period, all Part A hospital and skilled nursing facility benefits are renewed except
for any "lifetime reserve days" (see below) or psychiatric hospital benefits that were used. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility acute care.

Inpatient Hospital Care

If you are hospitalized, Medicare will pay all charges for covered hospital services during the first 60 days of a benefit period, except for the deductible (refer to the insert for the current Part A deductible amount). You are responsible for the deductible. In addition to the deductible, you are responsible for a share of the daily costs if your hospital stay lasts more than 60 days. For the 61st through the 90th day, Part A pays for all covered services except for a coinsurance amount (see insert for current Part A coinsurance amount). You are responsible for the coinsurance.

Part A does not pay for:

• The first three pints of whole blood or units of packed cells used in each year. (To the extent the 3-pint blood deductible is met under part B, it does not have to be met under Part A.)

• A private hospital room, unless medically necessary, or a private duty nurse.

• Personal convenience items, such as a telephone or television in a hospital room.

• Care that is not medically necessary or for non-emergency care in a hospital not certified by Medicare.

• Care received outside the U.S. and its territories, except under limited circumstances in Canada and Mexico.

Lifetime Reserve Days

Under Part A, you also have a lifetime reserve of 60 days for inpatient hospital care. These lifetime reserve days may be used whenever you are in the hospital for more than 90 consecutive days. When a reserve day is used, Part A pays for all covered services except for a coinsurance amount (see insert for current Part A coinsurance amount). Again, the coinsurance is your responsibility. Once used, reserve days are not renewed.

Skilled Nursing Facility Care

A skilled nursing facility is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a hospital. Medicare benefits are payable only if you require daily skilled acute care that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis, and the care is provided in a facility certified by Medicare. Medicare will not pay for your stay if the services you receive are primarily personal care or custodial services, such as assistance in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

To qualify for Medicare coverage for skilled nursing facility care, you must:

• Have been in a hospital at last three consecutive days (not counting the day of discharge) before entering a skilled nursing facility;
• Be admitted to the facility for the same condition for which you were treated in the hospital and the admission generally must be within 30 days of your discharge from the hospital; and

• Have your physician certify that you need to receive skilled nursing or skilled rehabilitation services on a daily basis.

Medicare can help pay for up to 100 days of skilled care in a skilled nursing facility during a benefit period. All covered services for the first 20 days of care are fully paid by Medicare. Medicare pays all covered services for the next 80 days except for a daily coinsurance amount (refer to the insert for the current Part A coinsurance amount). You are responsible for the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

Psychiatric Hospital Care

Medicare Part A helps pay for up to 190 days of inpatient care in a Medicare-participating psychiatric hospital in your lifetime. If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Inpatient care in a psychiatric hospital is subject to the same terms and conditions as inpatient care in a general hospital. If you receive psychiatric care in a general hospital, there is no limit on the number of days of care that you can receive during your lifetime.

Home Health Care

Medicare pays the full cost of medically necessary home health care visits by a Medicare-approved home health agency. A home health agency is a public or private agency that provides skilled nursing care, physical therapy, speech therapy and other therapeutic services. A visiting nurse and/or home health aide provides services on an intermittent or part-time basis.

To qualify for coverage, you must:

• Need intermittent, skilled nursing care, physical therapy, or speech therapy;

• Be confined to your home; and

• Be under a doctor's care.

A stay in the hospital is not needed to qualify for the home health benefit, and you do not have to pay a deductible or coinsurance for services. You do have to pay 20 percent of the approved amount for durable medical equipment such as wheelchairs and hospital beds provided under a plan-of-care set up and reviewed periodically by a doctor.

Part A does not pay for:

• Full-time nursing care and drugs;

• Meals delivered to your home;

• Twenty percent of the Medicare-approved amount for durable medical equipment, plus charges in excess of the approved amount on unassigned claims; and
• Homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

Hospice Care
Medicare pays for hospice care for terminally ill beneficiaries who choose to receive hospice care in lieu of most regular Medicare benefits for management of their illness. Under Medicare, hospice is primarily a program of care provided in the patient's home by a Medicare-approved hospice. The focus is on care, not cure. Hospice services covered under Medicare Part A are provided as long as a six-month life expectancy prognosis remains in effect. Services include:
• Physician services.
• Nursing care.
• Medical appliances and supplies.
• Drugs (for pain and symptom relief).
• Short-term inpatient care.
• Medical social services.
• Physical therapy, occupational therapy and speech/language pathology services.
• Dietary and other counseling.

There is no deductible for these hospice care benefits. Copayments are, however, required for the following two benefits:
1) Prescription drugs for pain relief and symptom management, for which patients can be charged 5% of the reasonable cost, but no more than $5 for each prescription.
2) Respite care, for which the patient can be charged about $5 per day, depending on the area of the country. The patient can receive inpatient care for up to 5 days per stay to provide some time off for the person who regularly provides care in the home.

If you need medical services for a health problem unrelated to the terminal illness, regular Medicare benefits are available. When regular benefits are used, you are responsible for any Medicare deductible and coinsurance amounts that must be paid.

Part A does not pay for:
• Limited charges for inpatient respite care and outpatient drugs as explained above.
• Deductibles and coinsurance when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

Enrollment Period
Individuals are automatically enrolled in Medicare Part A when they turn 65 years old (providing the appropriate amounts of FICA contributions were made). There is no cost to the individual for Medicare Part A.

Medicare Medical Insurance Benefits (Part B)
Medicare Part B pays for many medical services and supplies, but the most important coverage is for your doctor's bills. Medically necessary services of a doctor are covered no matter where you receive them—at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. Part B also covers:

- Outpatient hospital services.
- Certain vaccinations.
- Diabetes monitoring for Medicare-eligible diabetics.
- Bone mass measurements for Medicare beneficiaries at risk for losing bone mass.
- X-rays and laboratory tests.
- Certain ambulance services.
- Durable medical equipment, such as wheelchairs and hospital beds, used at home.
- Services of certain specially qualified practitioners who are not physicians.
- Physical and occupational therapy.
- Speech/language pathology services.
- Partial hospitalization for mental health care.
- Mammograms, Pap smears and pelvic exams.
- Colorectal cancer screening, fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, the frequencies of which vary by age or risk.
- One-time initial wellness physical exams (only if incurred within six months of the date first enrolled in Medicare Part B).
- Screening tests to detect cardiovascular diseases and diabetes.
- Home health care if you do not have Part A.

While Part B generally does not cover outpatient prescription drugs, it does cover some oral anti-cancer drugs, certain drugs for hospice enrollees, and drugs that you cannot administer yourself which are provided as part of a doctor's services. Certain drugs furnished during the first year after an organ transplantation and epoetin for home dialysis patients are also covered, as well as antigens, and flu, pneumococcal, and hepatitis B vaccines. Blood is also covered after you meet the 3-pint annual deductible.

**Part B Premium**

Most people pay the standard Part B premium each month. Some people may pay a higher premium based on their income. Your modified adjusted gross income is your adjusted gross (taxable) income plus your tax exempt interest income. The Part B premium is increased each year, if necessary, to fund about 25% of the projected cost of Part B. [Check the NEA Retired website for updated information.]

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Note that most people have their Part B premium deducted from their monthly Social Security benefit check. In 2010, Social Security benefits will not include a cost-of-living adjustment, which means Social Security benefit checks will not increase. However, the Social Security Act protects most people from having a decrease in their Social Security benefits from one year to the next because of an increase in the Part B premium. This means that most people who have the Part B premium deducted from their Social Security benefit check will continue to pay $96.40 each month. In 2010, retirees who get Part B beginning January 1, 2010, or later (new enrollees) will pay the increased premium as well as retirees with incomes above the amounts listed in the table above.

**Part B Deductible and Coinsurance**

When you use Part B benefits, you must pay a deductible each year of the charges approved by Medicare (refer to the insert for the current Part B deductible amount). After you meet the deductible, Part B generally pays 80 percent of the Medicare-approved amount for all covered services you receive during the rest of the year. You are responsible for the other 20 percent, which is called coinsurance.

Besides the deductible and coinsurance, you may also have other out-of-pocket costs if your doctor or medical supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount. The difference to be paid is called the "excess charge."

Sometimes, your share of the bill can be more than 20 percent of the Medicare-approved amount. If you receive outpatient services at a hospital, you pay 20 percent of whatever the hospital charges you, not 20 percent of an amount approved by Medicare. If you receive outpatient mental health services, your share is 50 percent of the Medicare-approved amount.

**What is the Medicare-Approved Amount?**

The amount Medicare approves for a covered service provided by a doctor will be the lesser of the Medicare fee schedule amount for a particular service or the amount charged by the doctor. The fee schedule lists the dollar amount that Medicare considers to be the reasonable charge for each of the services provided by a doctor that Medicare will help pay for.

**What is Assignment?**
Always ask your doctors and medical suppliers whether they accept "assignment of Medicare claims". If they do, they will accept the amount Medicare approves for a particular service or supply. That could mean savings for you.

In certain situations, all doctors and medical suppliers are required to accept assignment. For instance, all doctors and qualified laboratories must accept assignment for clinical diagnostic laboratory tests covered by Medicare. Doctors also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements.

Medicare law also requires physicians who do not take assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If the physician does not give you a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount for the surgery.

The names, addresses and telephone numbers of doctors and medical suppliers who accept assignment on all Medicare claims are listed in The Medicare Participating Physician/Supplier Directory. The directory is distributed to senior citizen organizations, all Social Security and Railroad Retirement Board offices, hospitals, and all state and area offices of the Administration on Aging. It also is available free by writing or calling the insurance company that processes Medicare Part B claims for your area. The names, addresses and telephone numbers of the companies, which are called Medicare "carriers," are listed in The Medicare Handbook, also available from any Social Security Administration office and online at: www.medicare.gov/supplier/home.asp.

Doctor Charge Limits

Doctors who do not accept assignment of a Medicare claim can charge up to 15 percent more than the Medicare-approved amount, and you are responsible for paying it. This is called the "limiting charge."

To determine the limiting charge for a particular service, contact the Medicare carrier for your area. Limiting charge information also appears on the Explanation of Medicare Benefits (EOMB) form usually sent to you by the carrier after you receive a Medicare-covered service. If the EOMB shows that your doctor exceeded the charge limit, contact the doctor and ask for a reduction in the charge, or a refund if you have paid the bill. If you cannot resolve the issue with the doctor, call your Medicare carrier.

Also, Medicare carriers are required to screen doctor bills for overcharges and notify the doctor and the patient within 30 days of any overcharge. The doctor is then required to refund the overcharge within 30 days or credit your account for it. Doctors who knowingly, willfully and repeatedly charge more than the legal limit are subject to sanctions.

Some states have enacted charge limit laws. To find out whether your state has a law limiting physician charges, contact your state insurance department counseling program or office on aging.

Other Charge Limits
Any non-participating doctor who provides you with services that he or she knows or has reason to believe Medicare will determine to be medically unnecessary, and thus will not pay for, is required to tell you that in writing before performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Other Gaps in Medicare coverage for Doctors and Medical Suppliers

In addition to the annual deductible, your requirement to pay 20% coinsurance, and legally permissible charges in excess of the Medicare-approved amount for unassigned claims, there are other items that Medicare doesn’t pay for:

- 50% of the Medicare-approved amounts for most outpatient mental health treatment;
- All charges of a private practice speech pathologist;
- All charges for most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury;
- All charges for most self-administrable prescription drugs and immunizations, except for pneumococcal, influenza and hepatitis B vaccinations, and certain oral cancer drugs;
- All charges for routine physicals and other screening services, except for periodic mammograms and Pap smears, and except for a covered one-time initial physical wellness exam if incurred within six months of the date you first enroll in Medicare Part B;
- All charges for most dental care and dentures;
- All charges for acupuncture treatment;
- All charges for routine eye examinations or eyeglasses, except prosthetic lenses after cataract surgery;
- All charges for hearing aids or routine hearing loss examinations;
- All charges for care outside the United States and its territories, except in certain instances in Canada and Mexico;
- All charges for routine foot care except when a medical condition affecting the lower limbs (such as diabetes) requires care by a medical professional;
- All charges for services of naturopaths, Christian Science practitioners, immediate relatives, or charges imposed by members of your household; and
- Unless replaced, all charges for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services; To the extent the 3-pint blood deductible is met under Part A, it does not have to be met under Part B.

Enrollment Period

There are three times when you can enroll in Medicare Part B. These are called:

- Initial Enrollment Period. The Initial Enrollment Period is a seven-month period that begins three months before the month you are first eligible for Medicare Part B. For
most people, the Initial Enrollment Period begins three months before the month you turn age 65. It ends three months after you turn age 65. If you are disabled and getting benefits from Social Security or the Railroad Retirement Board, the Initial Enrollment Period generally begins three months before your 25th month of entitlement.

You can sign up for Medicare Part B anytime during your Initial Enrollment Period. However, if you want Medicare Part B coverage to begin the month you turn age 65, you must sign up for it during the first three months of your Initial Enrollment Period. If you wait until you are age 65, or sign up during the last three months of your Initial Enrollment Period, your Medicare Part B start date will be delayed.

- General Enrollment Period. This period runs from January 1 through March 31 of each year. During this time, you can sign up for Medicare Part B at your local Social Security office. Medicare Part B coverage will start on July 1 of the year you sign up. Note that the cost of Medicare Part B will go up 10% for each full 12-month period that you could have had Medicare Part B but didn’t take it, except in special cases. The extra amount (called a premium surcharge) will have to be paid as long as you have Medicare Part B.

- Special Enrollment Period. This enrollment period is available if you are eligible for Medicare based on age 65 or disability but waited to enroll in Medicare Part B because you or your spouse were working and you had group health plan coverage through an employer or union based on this work. If this applies to you, you can sign up for Medicare Part B anytime while you are covered by the group health plan based on current employment status or during the eight-month period following the month the group health plan coverage ends or the employment ends, whichever is first.

If you are still working and plan to keep your employer’s group health plan coverage, you should talk to your benefits administrator or your State Health Insurance Assistance Program to help you decide the best time to enroll in Medicare Part B.

When you sign up for Medicare Part B, you automatically begin your Medicare Supplement Insurance open enrollment period (discussed in the next Chapter). Once your Medigap open enrollment period begins, it can’t be changed or restarted.

**Medicare Advantage (Part C)**

If you are entitled to Medicare Part A and enrolled in Part B, you are eligible to switch to a Medicare Advantage plan, provided you reside in the plan’s service area. Medicare Advantage provides the following options:

- Coordinated Care Plans (the Balanced Budget Act of 1997’s umbrella term for managed care plans);
  - HMO plans, otherwise known as Health Maintenance Organization plans, emphasize preventive care but without coverage for providers or facilities outside the HMO network. They almost always require a network primary care physician referral to access a network specialist; they usually offer drug benefits.
POS plans, otherwise known as Point of Service Plans, offer a network of preferred providers, like HMO plans, but also provide reduced benefits for providers or facilities outside the HMO network. They typically require a referral from a network primary care physician to access a network specialist; they sometimes offer drug benefits.

Regionally Expanded Preferred Provider Organization (PPO) plans are similar to POS plans but have broader geographic access to network providers in a larger service area, and with reduced benefits outside the PPO network. They do not typically require a referral from a network primary care physician to access network specialists. They may or may not offer drug benefits.

PSO plans, otherwise known as Provider-Sponsored Organizations, are similar to the POS plans but are usually organized with physicians that practice in a regional or community hospital. There may or may not be coverage for providers or facilities outside the PSO network, depending upon the plan designs offered. They may require a referral from a network primary care physician to access network specialists. They typically offer drug benefits.

Medical Savings Accounts set up in conjunction with private fee-for-service plans providing:

- at least the same benefit coverage levels as Medicare Parts A and B; or
- high deductible coverage.

Call 1-800-MEDICARE or visit [www.cms.hhs.gov/healthplans/rates/default.asp](http://www.cms.hhs.gov/healthplans/rates/default.asp) to determine what your plan choices are in your area.

Enrollment Period

To join a Medicare Advantage Plan, you must have Medicare Part A and Part B before you can get Part C. In addition, you might have to pay a monthly premium to your Medicare Advantage Plan for the extra benefits that they offer. Note, however, that some Medicare Advantage Plans offer good coverage for little, and in some cases, no cost.

Medicare Prescription Drug Plan (Part D)

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 added Part D. Medicare Part D pays for outpatient prescription drugs. The plan starts out with a $310 deductible in 2010 and will pay:

- 75% of the next $2,520 spent;
- Nothing for the next $3,600 spent; and
- 95% for drug bills over $6,440.

The deductible and cost-sharing limits can, and probably will, be adjusted in future years. [Check the NEA Retired website for updated information.]

The government guarantees drug coverage in any region that does not have at least one stand-alone drug plan and one private health plan. Employers that offer equivalent drug coverage for retirees can receive tax-free subsidies. Employers can also offer
premium subsidies and cost-sharing assistance for retirees who enroll in Medicare drug plans.

You may be eligible for help paying for some or all of your prescription drug costs, based on guidelines set by the federal government. You can apply for this help through the Social Security Administration or a state Medical Assistance Office. The amount of assistance you receive, if any, will depend on your income and resources, and is determined by the federal government.

Enrollment Period

Once you are eligible for Part D, you should receive a Disclosure Notice from your current health plan if you are an eligible active or retired employee or eligible spouse of an employee or retired employee who is covered by the current group health plan. The notice will inform you whether you have Creditable Coverage so you can decide whether to enroll in Part D.

If you do not have Creditable Coverage and do not enroll in Part D when first eligible, you may have to wait until the following November 15 to December 31 enrollment period to join Part D. In addition, you will face a late enrollment penalty of at least one percent per month if you decide to enroll after the later of the Initial Enrollment Period or date you first became eligible for Part D. You can avoid this penalty if 1) you enroll in Part D during the Enrollment Period when you are first eligible or 2) if you enroll after the Enrollment Period but demonstrate that you had no lapse greater than 62 days in coverage under your health plan that provided Creditable Coverage.

The Medicare Part D premium averages $32.00 per month. Some plans are available under $30 per month, but compare coverages from insurers like Blue Cross Blue Shield, UnitedHealth Care, and Aetna. If an eligible Medicare beneficiary puts off getting the Medicare Part D beyond the initial enrollment date, that individual will have to pay a higher monthly premium.

Part D Charts

The next two pages provide a visual aspect of what you pay and what Medicare pays for prescription drugs under the Part D program. The first page applies to 2009 amounts; the second page applies to 2010 amounts. [Check the NEA Retired website for updated information.]
Medicare Part D Coverage for 2009

Unlimited Coverage at 95%.

Once you have spent $4,350 in out-of-pocket expenses, the Medicare Plan will cover 95% of your drug costs.

$6,154 “Doughnut Hole”

After your total drug costs reach $2,700, you are responsible for all your drug costs up to $6,154 ($3,454).

$2,700 ($601) After the deductible, Medicare Plan covers 75% of the next $2,405 of your drug costs ($1,804).

$295 You have a $295 calendar year deductible.

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<th>You Pay</th>
<th>Medicare Plan Pays</th>
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<td>$4,350</td>
<td>Unlimited Coverage</td>
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<td>$2,700</td>
<td>“Doughnut Hole”</td>
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Medicare Part D Coverage for 2010

Unlimited Coverage at 95%.

Once you have spent $4,547 in out-of-pocket expenses, the Medicare Plan will cover 95% of your drug costs.

$6,440  “Doughnut Hole”

After your total drug costs reach $2,830, you are responsible for all your drug costs up to $6,440 ($3,610).

$2,830 ($630)  After the deductible, Medicare Plan covers 75% of the next $2,520 of your drug costs ($1,890).

$310  You have a $310 calendar year deductible.

You Pay  Medicare Plan Pays
MEDICARE SUPPLEMENT INSURANCE

Medicare usually covers only about half of the covered medical costs of America's senior citizens. In some cases, no additional coverage is necessary, such as for those who are eligible for Medicaid. However, most people feel more comfortable if they have a health plan that will supplement the protection available via traditional Medicare. Those health plans may be available from your school district or your spouse's employer if you are married. It may also be available through a Medicare Advantage plan that limits services to a select panel of hospitals and doctors.

Many individuals, however, find themselves in need of a new insurance plan – a Medicare supplement (or Medigap) plan – that fills in the gaps left by Medicare. Here are some factors to consider when shopping for Medicare supplement insurance:

- Premium prices. These can vary considerably between insurance carriers for the same coverage due to different factors. Some plans offer discounts to attract younger participants. Often these discounts disappear after a few years, leaving the older member to pay higher premiums.

- Community-rated pricing instead of attained age. Premiums for attained-age policies can balloon when the insured turns 75 or 80.

- Pre-existing condition clauses. Typically, there is a six-month period before Medicare supplement coverage becomes effective for expenses caused by a pre-existing health condition.

- Any special discounts or special benefits included with the coverage.

CAUTION -- Medicare supplement insurance is best purchased within six months of turning 65 and enrolling in Medicare Part B. During this six-month time frame, sometimes called "open enrollment," insurance companies selling Medicare supplement policies are legally required to accept anyone regardless of age or health condition. While all companies do not exercise it, they have the right to turn down those who apply outside of open enrollment periods for any reason.

Overview of Medicare Supplement Plans

In 1990, Federal law standardized Medicare supplement insurance into 10 coverage plans, known as Plans A through J. For Medicare supplement plans sold after December 31, 2005, the Medicare Modernization Act of 2003 (MMA) created two new plans, Plans K and L, and slightly changed some benefits for Plans H, I and J: MMA required the deletion of drug coverage in Plans H, I and J. Beginning June 1, 2010, plans E, H, I, and J will be eliminated with the introduction of plans M and N.

Each lettered Medicare supplement plan provides different types and amounts of coverage. Each state must allow the sale of Medicare Supplement Plan Option A, and all Medicare supplement insurers must make Medicare Supplement Plan Option A available.

Plan A includes the following "basic" benefits package:

- Part A copayments plus coverage for 365 additional days after Medicare benefits end;
- Part B copayment (20% of Medicare-approved expenses);
- The first three pints of blood each year; and
- All eligible hospice care and respite care expenses.

Massachusetts, Minnesota and Wisconsin, which had standardized Medicare supplement policies prior to 1990, were allowed to retain their own regulations and plan designs for insured plans filed within the state.

**Standard Medicare Supplement Plans**

According to the Consumers Union, Plan Options C and F are the most popular among seniors. Companies marketing Medicare supplement plans are generally required to display benefits for the plans available in a standard chart format. So that you will recognize the charts when you begin to receive materials from various insurance companies, illustrations appear at the end of this guide. An outline of the plan options appear on the following two pages; detailed explanations of each plan are provided after the charts.
Outline of Medicare Supplement Coverage (Sold after June 1, 2010)

Plan Options A, B, C, D, and F

Basic Benefits included in ALL Program Options:

Hospitalization: Part A copayment plus coverage for 365 additional days after Medicare benefits end.

Medical Expense: Part B copayment (20% of Medicare-approved expenses).

Blood: First three pints of blood each year.

Hospice Care: All eligible hospice care and respite care services.

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<th>Plan A</th>
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<td>Part B Excess (100%)</td>
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Outline of Medicare Supplement Coverage (Sold after June 1, 2010)

Plan Options G, K, L, M, and N

Basic Benefits included in All Program Options:

- Hospitalization: Part A copayment plus coverage for 365 additional days after Medicare benefits end.
- Medical Expense: Part B copayment (20% of Medicare-approved expenses).
- Blood: First three pints of blood each year.
- Hospice Care: All eligible hospice care and respite care services.

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<td>Skilled Nursing Co-payment</td>
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<td>Part A Deductible</td>
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PLAN A (the most basic policy) consists of these basic benefits:

- Coverage for the Part A coinsurance amount (see insert for current amount) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount (see insert for current amount) for each of Medicare’s 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder’s lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System (PPS) or under another appropriate standard of payment for hospitals not subject to the PPS.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 50% of approved charges for outpatient mental health services) after the annual deductible is met.
- Coverage for all Part A eligible hospice care and respite care services.

PLAN B includes the basic benefit plus:

- Coverage for the Medicare Part A inpatient hospital deductible (see insert for current Part A deductible amount).

PLAN C includes the basic benefit plus:

- Coverage for the Medicare Part A deductible;
- Coverage for the skilled nursing facility care coinsurance amount (see insert for current coinsurance amount); and
- Coverage for the Medicare Part B deductible (see insert for current Part B deductible amount). 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

PLAN D includes the basic benefit plus:

- Coverage for the Medicare Part A deductible; and
- Coverage for the skilled nursing facility care daily coinsurance amount. 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

PLAN F includes the basic benefit plus:

- Coverage for the Medicare Part A deductible;
- Coverage for the skilled nursing facility care daily coinsurance amount;
- Coverage for the Medicare Part B deductible;
- Coverage for 80% of medically necessary emergency care in a foreign country, after a $250 deductible; and
- Coverage for 100% of Medicare Part B excess charges.*

**PLAN G** includes the basic benefit plus:
- Coverage for the Medicare Part A deductible;
- Coverage for the skilled nursing facility care daily coinsurance amount;
- Coverage for 100% of Medicare Part B excess charges;* and
- Coverage for 80% of medically necessary emergency care in a foreign country, after a $250 deductible.

**PLAN K** pays 50% of the following expenses up to the annual Out-of-Pocket Limit ($4,620 in 2010):
- Basic Hospital Part A co-payments plus 365 additional days after Medicare payments end;
- Basic Medical Part B co-payments (20% of Medicare-approved expenses);*
- First three pints of blood each year;
- Skilled Nursing Facility Co-Insurance; and
- Part A Deductible.

**PLAN L** pays 75% of the following expenses up to the annual Out-of-Pocket Limit ($2,310 in 2010):
- Basic Hospital Part A co-payments plus 365 additional days after Medicare payments end;
- Basic Medical Part B co-payments (20% of Medicare-approved expenses)*;
- First three pints of blood each year;
- Skilled Nursing Facility Co-Insurance; and
- Part A Deductible.

**PLAN M** (effective June 1, 2010) includes the basic benefits plus:
- Coverage for 50% of the Medicare Part A deductible;
- Coverage for the skilled nursing facility care daily coinsurance amount;
- Coverage for 80% of medically necessary emergency care in a foreign country, after a $250 deductible.

**PLAN N** (effective June 1, 2010) includes the basic benefits plus:
- Coverage for the Medicare Part A deductible;
- Coverage for the skilled nursing facility care daily coinsurance amount;
Coverage for 80% of medically necessary emergency care in a foreign country, after a $250 deductible.

Plan N adds a new co-payment structure of $20 for each physician visit and $50 for each emergency room visit (waived upon admission to the hospital).

*Note: Plan pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

Pre-Existing Conditions

Medicare supplement insurers are allowed to limit your coverage for "pre-existing conditions." Preexisting conditions are generally health problems you went to see a physician about within the six months before the date the policy went into effect. Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you immediately for expenses connected with that problem. Medicare supplement policies, however, are required to cover pre-existing conditions after the policy has been in effect for six months. Also, if you switch from one Medicare supplement plan to another, the new plan can't impose a pre-existing conditions waiting period for benefits covered under the old plan.

Open Enrollment Guarantees Your Right to Medicare Supplement Coverage

State and Federal laws guarantee that for a period of 6 months from the date you are both enrolled in Medicare Part B and age 65 or older, you have a right to buy the Medicare supplement policy of your choice regardless of any health problems you may have. If, however, your birthday falls on the first day of the month, your Part B coverage (if you buy it) begins on the first day of the previous month, while you are still 64. Your Medicare Supplement Plan Open Enrollment Period would also begin at that time.

During this 6-month open enrollment period, you can buy any Medicare supplement policy sold by any Medicare supplement marketer conducting business in your state. The company cannot deny or condition the effective date, or discriminate in the pricing of a policy because of your medical history, health status or claims experience. The company can, however, impose the same preexisting condition restrictions that apply to Medicare supplement policies sold outside the open enrollment period.

Your Medicare card shows the effective dates for your Part A and/or Part B coverage. To figure whether you are in your Medicare supplement open enrollment period, add 6 months to the effective date of your Part B coverage. If the date is in the future and you are at least 65, you are eligible for open enrollment. If the date is in the past, you are generally not eligible. (If you were entitled to Medicare before age 65, see the following section on open enrollment and the disabled.)

If you or your spouse is covered under an employer group health plan when you become eligible for Part B at age 65, your Medicare Supplement Plan Open Enrollment Period will not start until you sign up for Medicare Part B. Once you enroll in Medicare Part B, the 6-month Medicare Supplement Plan Open Enrollment Period starts and cannot be extended or repeated. However, your employer health plan may require you to enroll in Medicare Part B in order to receive benefits under your employer health plan. If your employer had less than 100 employees (including temporary or part-time
employees) during the plan year who worked at least 50% during the plan year period, then your employer health plan is *secondary* to Medicare for that plan year period.

**Medicare Supplement Open Enrollment and the Disabled**

If you become eligible for Part B benefits before age 65 because of a disability or permanent kidney failure, federal law guarantees you access to the Medicare Supplement policy of your choice when you reach age 65. During the first 6 months you are age 65 and enrolled in Part B, you can buy the policy of your choice regardless of whether you had enrolled in Part B before you were 65.

During these 6 months, you cannot be refused a policy because of your disability or for other health reasons. Moreover, you cannot be charged more than other applicants, which can greatly reduce the amount you are paying. This includes Medicare supplement policies that cover outpatient drugs, if they are available in your state. A waiting period of up to 6 months, however, may be imposed for coverage of a pre-existing condition.

**Guaranteed Renewable**

All standard Medicare supplement policies are guaranteed renewable. This means that the insurance company cannot refuse to renew your policy unless you do not pay the premiums or you made material misrepresentations on the application. Older policies may allow the company to refuse to renew on an individual basis. These older policies provide the least permanent coverage.

**Older Medicare Supplement Policies**

Many federal requirements do not apply to Medicare supplement policies sold before 1992, when Medicare supplement plans were standardized. There is generally no requirement that you switch to one of the standard plans if you have an older policy. However, you may be required to switch if your older plan was not guaranteed renewable and the company discontinues the type of policy you have. Check with your state insurance department to find out what state-specific requirements are in force.

**Switching Medicare Supplement Policies**

Even if you are not required to convert an older policy, you may want to consider switching to one of the standardized Medicare supplement plans if it is to your advantage and an insurer is willing to sell you one. If you do switch, you will not be allowed to go back to the old policy. Before switching, compare benefits and premiums, and determine if there are waiting periods for any of the benefits in the new policy. Some of the older policies may provide better coverage, especially for prescription drugs and extended skilled nursing care. On the other hand, older Medicare supplement policies, which cannot be sold to new applicants, may experience greater premium increases than newer standardized policies which can enroll new applicants (younger, healthier policyholders’ better claims experience will help to moderate premium increases).

If you have had a Medicare supplement policy for at least 6 months and you decide to switch, the replacement policy generally cannot impose a waiting period for a preexisting condition. If, however, a benefit is included in the new policy that was not in
the old policy, a waiting period of up to 6 months—unless prohibited by your state—may be applied to that particular benefit.

You do not need more than one Medicare supplement policy. If you already have a Medicare supplement policy, you must sign a statement when you buy another indicating that you intend to replace your current policy and will not keep both policies. However, do not cancel the old policy until the new one is in force and you have decided to keep it.

Use the "Free-Look" Provision

Companies must give you at least 30 days to review a Medicare supplement policy. If you decide you don't want the policy, send it back to the agent or company within 30 days of receiving it and ask for a refund of all premiums you paid. Contact your state insurance department if you have a problem getting a refund.

Non-Standard Plans

It is illegal for anyone to sell you a Medicare supplement plan that does not conform to Medicare supplement standardization requirements. This may include a "retainer agreement" that your doctor may offer you under which he or she will provide certain non-Medicare-covered services and waive the Medicare coinsurance and deductible amounts. This arrangement may violate federal laws governing Medicare supplement policies. If a doctor refuses to see you as a Medicare patient unless you pay him or her an annual fee and sign one of these retainer agreements, you should register a complaint with federal authorities by calling 1-800-MEDICARE (1-800-633-4227).

Carrier Filing of Medicare Supplement Claims

Under certain circumstances, when you receive medical services covered by both Medicare and your Medicare supplement insurance, you may not have to file a separate claim with the insurer of your Medicare supplement insurance in order to have payment made directly to your doctor or medical supplier.

By law, the Medicare carrier that processes Medicare claims for your area must send your claim to the Medicare supplement insurer for payment when the following four conditions are met for a Medicare Part B claim:

1. Your doctor or supplier must have signed a participation agreement with Medicare to accept assignment of Medicare claims for all patients who are Medicare beneficiaries;

2. Your policy must be a Medicare supplement policy;

3. You have provided your Medicare supplement policy Medicare Claim Number; and

4. You have instructed your doctor to indicate on the Medicare claim form that you wish payment of Medicare supplement benefits to be made to the participating doctor or supplier.

When these conditions are met, the Medicare carrier will process the Medicare claim, send the claim to the Medicare supplement insurer and generally send you an *Explanation of Medicare Benefits* (EOMB). Your Medicare supplement insurer will pay
benefits directly to your doctor or medical supplier and send you a notice that it has done so.

If your Medicare supplement insurer refuses to pay the doctor directly when these conditions are met, you should report this to your state insurance department. For more information on Medicare supplement claim filing, contact the Medicare carrier. Look in *The Medicare Handbook* for the name and telephone number of the Medicare carrier for your area.

Under another arrangement, some Medicare supplement insurers have "crossover" contracts with Medicare. If your company has a crossover contract, Medicare will automatically send all of your claims directly to the Medicare supplement insurer, even if the doctor has not signed a participation agreement with Medicare.

**Medicare Summary Notice**

The Medicare Summary Notice is an easy-to-read monthly statement that clearly lists your health insurance claims information. It replaces the Explanation of your Medicare Part B Benefits, the Medicare Benefit Notice (Part A) and Benefit Denial Letters. After reading the notice, you may call the phone number listed in the Customer Service Information box on the front of the Medicare Summary Notice, with questions, or you can follow the instruction on the Medicare Summary Notice to file an appeal if you disagree with a claims decision.

MEDICAID

Medicaid eligibility is determined not by age but by income and several other factors. Only those in certain categories qualify, including:

- Children in low income families.
- Pregnant women.
- The elderly (those eligible for Medicare who cannot afford it).
- People with disabilities.

Each state devises and administers its own Medicaid program, following Federal government guidelines, through matching funds based on that state's per capita income. The Federal government picks up anywhere from 50 percent to 80 percent. Within these Federal guidelines, states have considerable latitude to establish their own Medicaid programs. As a result, coverage and administration vary widely from state to state.

One of the most widespread problems with Medicaid is a controlled reimbursement level, which discourages private health care providers from accepting Medicaid patients. Those receiving Medicaid health care pay either nothing or only small fees. Medicaid is actually more comprehensive in the kinds of services it pays for than Medicare. Medicaid will even pay for costs not covered by Medicare for the elderly who otherwise qualify for Medicare but cannot afford the Part A hospital deductible or Part B premium.

Under the new welfare program established in 1996, families receiving cash assistance are no longer automatically eligible for Medicaid. Another major change began Oct. 1, 1998, when the new, federally mandated state Child Health Insurance Program, or CHIP, expanded health care coverage to uninsured children of low income families, either through Medicaid or a separate program.

Medicaid enrollment rose dramatically in the early 1990s before beginning to level off. In 2007, over 47 million people (half through the CHIP program) were enrolled in Medicaid at an annual cost of $329 billion, according to the Centers for Medicare & Medicaid Services. Even so, Medicaid serves only about half the nation's low-income population. As with Medicare, the federal government is encouraging states to enroll Medicaid recipients in health maintenance organizations (HMOs) or managed care organizations (MCOs) as a way to keep a lid on rising costs.

On February 8, 2006, President Bush signed the “Deficit Reduction Act of 2005.” The Congressional Budget Office estimates the legislation will save about $39 billion over the 2006 to 2010 period, and $99 billion over the 2006 to 2015 period through ten categories or “Titles” of expense items. The biggest savings, however, will come from reductions in three areas, namely, a) Education Funding (over $32 billion); b) Medicare Funding (over $22 billion); and c) Medicaid Funding (over $28 billion), leaving about $17 billion in savings over the remaining 7 Titles. Of these, Medicaid cuts will mean difficulty for many of our members needing federal and state assistance with long-term care costs.
LONG-TERM CARE INSURANCE

LTC insurance is designed principally to provide a daily cash benefit to cover the costs of health care services provided in a nursing home, your own home, an assisted living facility, or an adult day care facility. This type of insurance does not provide a benefit based upon one's ability to work. Instead, it provides benefits based solely on one's ability to perform or not perform certain daily functions, known as “Activities of Daily Living” or “ADLs.” The average annual cost for nursing home care in the United States is $79,935 (private room), according to the 2009 MetLife Market Survey of Nursing Home and Home Care Costs. [Check the NEA Retired website for updated information.]

The highest probability of needing care occurs in the last one-third of a person's life span, so the older you become the faster the premiums rise. Probably the ideal time to purchase such a policy is when you are less than 55 years of age. You may qualify for acceptance even if your health is not perfect. However, you are more likely to qualify for a lower premium if your health at the time you apply is better than others the same age. People who wait too long to apply may not be accepted because of their state of health and/or the need for assistance to perform the ADLs.

Here are some reasons to purchase LTC insurance:

- You might be able to afford LTC care for a few months, but not have enough savings to maintain an acceptable lifestyle for your dependents should you need continual assistance for several years to perform ADLs: bathing, dressing, eating, continence, transferring, toileting.
- You have assets of $75,000 or more that you want to leave as an inheritance and don't want squandered on long-term care expenses.
- You care about quality choices of LTC facilities and want to control how you receive your LTC care.
- You want to pay for your own care without becoming destitute.
- You can afford the premiums.

LTC insurance is probably not needed if:

- You have adequate resources to pay for your long-term care without impacting the lifestyle of your dependents.
- You are not concerned about leaving an inheritance.
- You are not selective about where you might receive long-term care.
- You have minimal savings such that you will quickly qualify for Medicaid assistance for LTC expenses.
- You cannot afford the premiums.

The cost of LTC insurance is related to such factors as:

- Amount of protection required.
- Over how long of a period benefits will be paid.
- Length of the waiting period until benefits begin.
- Applicant's age.
- Applicant's state of health.
- Types of coverage chosen.

NEA Member Benefits has partnered with John Hancock Life Insurance Company to provide a quality long-term care insurance program, with member-only benefits (available in most states – check with Long Term Care Financial Partners to verify).
Life Insurance

Life insurance is for the benefit of those who have an *insurable interest* in the one who is insured. There are two general categories of life insurance: term and cash value. Term life insurance insures you for a set period of time or term, e.g., one year, five years, 10 years, 20 years, 30 years or to a certain age, etc. You are buying a benefit that pays your beneficiary the face amount of your policy when you die. The second type, cash value life insurance, pays you cash, should you decide you want to terminate the policy at some point in the future. You can also borrow the cash value and continue paying premiums to maintain the face amount balance of the policy after the cash value loan is subtracted.

The important thing to remember is that the death-protection-only element of term life insurance makes term coverage less expensive than the same face amount payable under ordinary life—often 3 to 10 times cheaper. Anyone with a need to replace a large loss of income in the event of your death will most likely want a term life plan because it's cheaper.

**Term Life Insurance**

Term life insurance provides the face amount of the policy upon the death of the insured. If the insured does not die, then the term life insurance ends. It also may offer an option to renew up to a certain age, regardless of your health, but typically at a higher premium or lower face amount.

Decreasing Term Life Insurance, for which benefits decrease over time, usually to liquidate the declining balance of an obligation or loan. For example, you may want to pay off your home mortgage upon your death to relieve your dependents of the debt.

**Ordinary Life Insurance**

Ordinary, or whole life insurance, is a type of cash value life insurance which pays the face amount to your beneficiary when you die. You can name anyone, even a trust, as a beneficiary. Tax consequences to the beneficiary vary, depending upon who the policy owner is.

What makes ordinary life insurance different from term life insurance? An ordinary life insurance policy is a combination of a term insurance policy and a “savings account.” The policy owner pays a level premium, which is usually higher in the early years, and excess amounts are used to fund the savings account (also known as the cash value). Ordinary life insurance allows the policy owner to choose one of the following options, also known as “non-forfeiture provisions,” even if the insured doesn't die:

- receive some of the premium back in the form of a low-cost policy loan
- surrender the policy for cash
- receive a reduced life insurance benefit at death
- continue the current life insurance benefit for a reduced time period

An ordinary life insurance policy combines the term life insurance policy’s cash value grows based on a set interest rate. Most insurance companies will provide a minimum (or guaranteed) interest rate and a “current” (usually higher) interest rate. Be careful of
the guaranteed and current interest rates because if they are under today’s inflation rate, you will ultimately be losing money. In addition, some policies will include a sales charge if your cancel your policy within 10 years of the effective date (sales charge applied to the cash value amount).

Other Types of Cash Value Life Insurance

Universal Life Insurance. You can pay either a full premium that includes the savings portion, or only the minimum required to pay the death benefit. If you also pay for the savings element, then you can miss some premium payments in the future and still keep the policy in force.

Eventually, however, the savings portion can run out, and you must then pay the minimum premium for death protection to keep the policy in force. Generally, universal life insurance pays a higher interest rate on the savings element than ordinary life policies pay, but not necessarily in times when interest rates on government and highly rated corporate bonds are low.

Universal life insurance offers the possibility of a larger death benefit than that available with ordinary life insurance. The savings element can be added to the face amount as an additional death benefit at the death of the insured. The cash value savings portion of ordinary life insurance pays only the policy's original face amount, which includes the savings portion.

Variable Universal Life. Variable universal life has many of the same characteristics as the universal life policy, including additional death benefits from the savings portion when the insured person dies. Instead of guaranteeing a minimum interest rate on the policy's savings portion, it is invested in the stock market. While it is unlikely that an insurer selling this type of policy would allow all of its stock market investments to lose all their value, there is the possibility that it could happen, and this would affect the final death benefit payable to a beneficiary.

Over a long period of time, investments in the stock market will likely exceed the value of fixed-dollar investments like bonds, mortgages, and money-market funds. That makes the death benefit potentially more from a higher savings element of the variable universal life insurance over straight universal or ordinary life insurance. This type of policy is not recommended, however, if you want to guarantee a specified death benefit for your heirs.

Death Benefit At Low Cost

You'll want to get a guaranteed death benefit at the lowest cost possible. That usually means buying term life insurance. If you can afford to buy the amount of insurance you need by buying one of the cash value life alternatives with a savings element described above, look into several insurers and compare their premiums and their cash values after 10 and 20 years.

CAUTION: most life insurance agents will push cash value life insurance instead of term life insurance because of the high commissions they receive from cash value life insurance premiums. Be sure to ask questions if you do not understand the policy.
If you own property and have a mortgage or have a spouse/domestic partner, children or an elderly parent who depend on you for support, you probably need to maintain some life insurance even in retirement.

You may want to provide funds for final expenses from the proceeds of insurance: life insurance can solve immediate needs for your heirs including final expenses, unpaid medical bills, and estate expenses. There are increasing exemptions from federal estate taxes. However, the law is set to expire in 2011 unless Congress enacts a change. [Check the NEA Retired website for updated information.]

In some cases the proceeds of life insurance can be used to pay estate taxes in the case of a large estate.

When you are older and retired, you may have difficulty buying new life insurance, so consider maintaining your current policies as long as you

- need the coverage and
- can afford the premium.

NEA Members Insurance Trust offers several cost-effective options for you to consider. You can click on each one below to learn about the features and rates.

**NEA LEVEL PREMIUM INSURANCE PLAN**
Added protection at a locked-in rate may help offset the loss of value of other policies due to inflation

**NEA AD&D PLUS INSURANCE PLAN**
Rest assured, you’re covered all the time wherever you go—now with more benefits than ever

**NEA GUARANTEED ISSUE LIFE**
As an NEA-R member, you cannot be turned down for this valuable coverage.
Auto Insurance

As a retired member, you have probably been buying auto insurance for many years. Nevertheless, it never hurts to re-evaluate your coverage to make sure you have the right fit for your current situation.

All United States citizens are required to have auto insurance if they want to drive a car or truck on public roads. Premiums differ as a function of the specific risk profile for each insured person. It is helpful to assess the proper amount of coverage you need to adequately protect your assets in the event of an accident you or a family member sustain or cause.

A Personal Auto Policy provides bodily injury (liability) and property damage insurance for the insured, passengers, and any person(s) harmed in an accident. Most policies are identifiable by a three-part designation, such as 100,000/300,000/100,000. The first number indicates the insurance company's dollar limit of liability for bodily injury per person. The second number gives the bodily injury maximum dollar benefit per occurrence, and the third number provides the property damage dollar limit per accident.

The following outlines the different coverages that are found in a typical insurance policy. Some coverages can be excluded, while others are highly desirable and/or required by the state.

**Bodily Injury Liability:** In an accident where the insured is found to have been at fault, this coverage pays for the medical treatments, rehabilitation, or funeral costs incurred by another driver, the other driver's passengers, passengers in your car, and pedestrians. The coverage also pays legal costs and settlements for non-monetary losses (pain and suffering).

**Property Damage Liability:** Covers repair or replacement of other people's vehicles or property that someone, covered on the insured's policy, damages in an accident. Each state requires drivers to have property damage liability coverage up to certain specified limits, typically $15,000 per accident.

**Collision and Comprehensive:** Pays for the repair of your car or replacement of its market value, regardless of who was at fault. Comprehensive pays for replacement or repairs if the insured's car has been stolen or damaged as a result of events such as fire or windstorm.

**Medical Payments:** Pays physicians and hospital bills, rehabilitation costs, lost income, and some funeral expenses for the insured and the insured's passengers. It also pays limited compensation for services needed during convalescence.

**Personal Injury Protection:** A broader form of Medical Payments coverage that covers medical and funeral costs for the insured and members of their household. It also pays a portion of lost wages and the costs of in-home assistance.

**Uninsured and Underinsured Motorist Coverage:** Pays the insured and members of their household for medical costs, rehabilitation, funeral costs, and losses from pain and suffering resulting from an accident caused by a hit-and-run driver, or by a driver who lacks sufficient insurance or who has no insurance at all.
**Uninsured Motorist Property Damage:** Pays for damage to the insured's property by someone without insurance, or without enough insurance to reimburse the insured's costs.

**Glass Breakage:** Pays for replacement of cracked glass to the insured's car, regardless of how it occurred.

**Rental Reimbursement and Towing:** Pays for towing the wrecked vehicle and the payment for a car rental while the automobile is being fixed after an accident.

**TIP:** You may want to consider purchasing expanded coverage over the limits of your liability protection. This might be necessary if you are concerned with potential bankruptcy as a result of a huge judgment against you. Some insurers offer an "umbrella policy" which wraps around the basic coverage of your auto policy to protect you against potentially large judgments against you such as $1 million or multiples thereof. Your basic auto policy limits would pay first and this umbrella coverage would take up any excess up to the limits of the umbrella policy.

**Here are some money-saving tips when purchasing auto insurance:**

Changing or adding cars can affect both the coverages and the rates you pay. Be sure to report new or replacement vehicles to your insurance company immediately to avoid the risk of an uninsurable loss. You should review current coverages because they may provide insufficient protection for the replacement of additional vehicles.

You may save premium dollars if:

- you and the other covered drivers have an accident-free record.
- you own more than one car and insure them with the same company (multi-car discount).
- you have your homeowners/renters/condominium insurance with the same company (multi-policy discount).
- you use your car for pleasure only.
- you are able to purchase the Special Package Auto Policy.
- you choose a higher deductible for collision coverage.

You can lower costs with a higher deductible for comprehensive and collision coverage; but if you have a loan out on your car, the lending institution may limit the deductible amount of collision and comprehensive coverage. You may also lower premiums if your car has an anti-theft device; or your insurance company returns dividends to you at the end of year.

The higher the coverage limits or lower the deductible amount, the higher the premium. However, an individual should not compromise liability and property damage coverage for a lower premium. Most insurance companies will recommend raising the comprehensive or collision deductible to lower the insurance premium.

**NEA Member Benefits** has partnered with California Casualty Insurance Company to provide a special auto insurance program with member-only pricing and benefits (available in most states).
Homeowners or Rental Insurance

Homeowner’s insurance can describe the insurance for your primary residence (single-family home or townhouse), the contents of the place you are renting (renter’s insurance), or the condominium you own (condo insurance). Four important parts of a homeowner’s policy are:

Coverage A—Dwelling. The primary dwelling is covered for its full replacement value (providing that the coverage amount increases as the labor and materials cost increase in your area).

Coverage B—Other Structures. Any structures not attached to the dwelling — that is, fences, swimming pools, and sheds — are protected for 10 percent of the Coverage A amount.

Coverage C—Personal Property. Your personal property — that is, clothes, jewelry, furniture, pots/pans, and computers — is protected at home or anywhere in the world. The level of protection is 50 percent of the Coverage A amount (an endorsement that covers the property to its full replacement value if a loss occurs increases the level of protection to 70 percent). Certain types of property will be eligible for only limited amounts of coverage.

Coverage D—Loss of Use. Pays the extra expenses (hotel stays, higher-cost meals) incurred when a residence becomes uninhabitable from a covered loss — usually from a fire. The level of protection is 20 percent of the Coverage A amount.

Additional levels of coverage are provided in the standard homeowner’s policy, for example for fire department service charges, replacement costs for trees and shrubs, and credit card losses. Exclusions include intentional losses and the loss of business uses.

Homeowner’s insurance also provides liability protection for your property. The following protections are included in your policy:

Coverage E—Liability. Insurance is provided for other individuals (i.e., those not residing in the residence) who are injured on your property or who are injured off your property from a family member’s negligence. For example, you are protected if someone slips on your icy steps and decides to sue you.

Coverage F—Medical Payments. Coverage F works with Coverage E in that it provides medical payments coverage to injured individuals. For example, the person who slips on your front steps, your policy provides coverage (usually $2,000) for that person’s medical claims. The premise is that the person may not sue you if you take care of her or his immediate medical bills.

As with the property protection, several exclusions apply to liability protection. One exclusion of special interest is protection of business pursuits; any injuries or claims resulting from a business operated within your residence will not be covered.

NEA Member Benefits has partnered with California Casualty Insurance Company and Horace Mann Insurance Company to provide special home insurance programs with member-only pricing and benefits (available in most states).
MOBILE HOMES

Mobile homes are a growth industry. According to the Manufactured Housing Institute (MHI), mobile homes account for about 25 percent of new residential construction and home sales each year in the United States, and more than 10 percent of total housing. In many rural areas, the percentage is even higher. Cost is a major benefit; according to the U.S. Census Bureau, the average price for a new single section manufactured home in 2008 is about $38,100 (double-section homes are larger at around 1,900 square feet of living space with a selling price of about $76,100). [Check the NEA Retired website for updated information.]

The MHI defines a mobile home as "a single-family house constructed entirely in a controlled factory environment, built to the federal Manufactured Home Construction and Safety Standards, better known as the HUD (Housing and Urban Development) Code." The organization prefers the term "manufactured home," noting that "mobile home" is the term used for homes built prior to June 15, 1976, when the HUD Code went into effect. All mobile homes built since 1977 must adhere to the HUD code regulations, which include federal standards for design and construction, fire resistance, energy efficiency, and quality.

In general, when insuring any home, there are three major areas of risk that you want to protect against: damage to your home, theft of property from your home, and your legal liability for injuries or property damage. There are certain insurance pricing factors you can't control. If you live in an area with a comparatively high crime rate, or where there has been persistent flooding, you can expect higher premiums.

Mobile home owners need to pay attention to more than just the cost of a policy. They also need to find out what coverage is included. Some policies are comprehensive, while others cover only specific causes of loss or "named perils." Liability coverage, deductibles and coverage limits can vary from company to company and from policy to policy. The best policy includes a "replacement cost" option, which will replace whatever has been damaged, up to the policy limit. As a mobile home owner, you need to shop around for the best deal and the best policy to suit your needs.

MOTOR HOMES

Motor homes, also referred to as "recreational vehicles" (RVs), are treated much differently than mobile homes for insurance purposes. While the protection for motor homes is more akin to automobile insurance, there are nevertheless many differences. According to the Recreational Vehicle Industry Association, RVs are specialized vehicles with unique insurance needs. Coverage on furnishings, fixtures, appliances, and personal items are among the many differences between regular automobile and RV insurance. The high cost of RVs and the potential for extensive physical damage in an accident mean the ordinary coverage minimums that apply to passenger cars are too low. Additionally, since many RVs are driven by people who aren't accustomed to the vehicle's extra size and length, insurers believe there is a greater risk for accidents.

Some carriers will issue a certificate of insurance that applies to a motor home. In other cases, if you have rental car coverage as part of your automobile insurance package, it will apply, but only if your physical damage limits are increased. If your insurer will sell
you coverage with higher limits, that might be your best choice. If not, you'll have to find an independent agent who can write policies in the "specialty market."

**Insuring a Rented RV**

If you are renting an RV, you'll need to make sure you have adequate insurance. Many companies that rent RVs offer insurance, but it might not be the best deal. Here are some of the things to watch for when renting an RV:

- Is the insurance included in the rental price? If not, does the stand-alone price make sense? A $12-a-day insurance policy might not seem like much, but over a year's time that would work out to more than $4,300 for the policy.

- What is the deductible amount? Most RV policies start with a $500 deductible and go as high as $2,000. How much are you willing to pay out-of-pocket if you have to make a claim?

- Is the liability coverage adequate? Most states require motorists to carry a minimum amount of liability insurance. You should have at least $100,000 of liability protection, as well as $100,000 of property damage protection.

- Are the limits high enough? Remember that a fender-bender in a 27-foot motor home can run $2,000 or more, compared with $400 or $500 for a similar accident in your four-door sedan.

- Are you covered for towing? Half of the fun of an RV vacation is traveling to remote areas far from fast-food franchises, motels - and repair shops. If you have a breakdown 60 miles from the nearest mechanic, the bill for an oversize wrecker to come and get you could be pretty high. Your policy should provide for high towing limits.

- Does the policy exclude drivers under age 25? Some policies include a flat-out exclusion. Others give the agent leeway in determining whether a younger driver is mature enough to handle the vehicle. If your policy excludes a younger driver, an accident that occurs while the excluded driver is behind the wheel will not be covered.

- Are you covered for medical expenses if someone is injured? Check the medical payment and personal injury provisions of the policy to make sure that you and your passengers are covered for medical expenses.

- Does the policy provide replacement cost for personal property damaged or stolen from inside the motor home? Your golfing vacation could be seriously hampered by the loss of your clubs. Find out if your policy will allow you to replace personal property. If not, check to see if your homeowners insurance might cover these items.
NATIONAL FLOOD INSURANCE PROGRAM

Contrary to popular belief, losses caused by flooding are not covered under a homeowner's insurance policy. Flooding can be devastating, as proven by the 2005 hurricanes. Insurance is available through only one source — the U.S. federal government. The National Flood Insurance Program provides protection to your dwelling and personal property. Although many different organizations can sell flood insurance, only the U.S. government sets the rates and pays the claims. Note that the Federal Disaster Assistance Program only provides loss assistance — usually through no- or low-interest loans — which must be paid back.

To purchase federal flood insurance, your community must participate in the federal National Flood Insurance Program. Everyone who lives in areas at great risk for flooding (called special flood hazard areas, or SFHAs) is entitled to buy federal flood insurance. To receive a federally backed housing loan, the National Flood Insurance Act requires borrowers who want to live in an SFHA to purchase flood insurance. Conventional loans on property within coastal barrier resources system areas do not require flood insurance, but lenders are required to notify borrowers that their property is situated in an SFHA, and borrowers are entitled to purchase federal flood insurance.

Limits to Flood Insurance

The following limits apply to flood insurance:

- $250,000 per multi-family unit or single-family residential buildings
- $100,000 for contents, also available to renters
- $500,000 each for commercial structures and contents

Check the NEA Retired website for updated information.

30-Day Waiting Period

Although you can apply for coverage at any time, no coverage is available, with few exceptions, until a 30-day waiting period after you have applied for coverage and paid the premium. To be covered, flooding must be a general and temporary condition during a period when the surface of normally dry land is partially or completely inundated, so that two or more acres or two adjacent properties become flooded.

Perils covered by flood insurance:

- inland or tidal water overflow (which can occur as the result of the failure of a dam or levee).
- flooding that causes mudslides or mudflows.
- floods caused by unusual or rapid accumulation or runoff of surface waters from melting snow or heavy rainfall.
- damage resulting from the collapse or instability of land along a body of water from the eroding effects of moving water.
- floods caused by hurricanes, with the exception of risks covered by your regular property and liability policy, such as from hail or from rain entering as a result of wind damage.
damage to basements or any area with a floor that is below ground level on all sides, including cleanup expenses and damage to appliances or equipment located in the basement, with the exception of the contents of a finished basement and improvements such as finished walls, floors, or ceilings.

**Federal Disaster Area**

Note that if a community is declared a federal disaster area, assistance in the form of no- or low-cost federal loans may become available (awarded less than 50 percent of the time), but this does not relieve you of your responsibilities on your original mortgage.
IV. ESTATE PLANNING

Wills

According to Webster’s New Collegiate Dictionary the definition of a Will is "A legal declaration of a person's mind as to the manner in which he would have his property or estate disposed of after his death." If we break down the definition it tells us a great deal of information as to why a person should have a will. Without a will somebody else, most likely a court, will act as your mind trying to figure out what to do with your assets and perhaps even your children, if they are minors. Creating a will is something that a great many people know they need to do but it is something they find reason to put off to some later date.

If you don't have a will ask yourself this question: "Do you know of anybody who has died without a will and what happened to their family?" The first thing that happens is all the assets are frozen. Until the court grants access, no one can do anything with the assets. If minor children are involved, then the court will want guardians for each child to protect their interest. In many states, if the husband dies without a will and there are children, one third of the assets will belong to the wife and two thirds of the assets will belong to the children. If you had a will, you could leave all of your assets to your spouse and, after the spouse's death, the remaining assets will go to the children.

In some cases, you can use a will to hold a trust. Simply put, a trust is used to distribute your assets over some extended period of time. The will creates an orderly distribution of your assets. The will lets you decide who will receive what on your death. You can use a will to make a gift of certain assets to a specific person. You can use your will to determine the order of the distribution of your assets. For example, you might want to give some money to your college first and then decide what happens to the rest of your money.

Wills don't have to be difficult documents to set up and they are not that expensive. Depending on where you live and how complicated your distribution, a basic will should cost between $300 to $500 dollars.

Who is a Candidate for a Will?

- Someone who is married or has been married more than once.
- Someone who has children.
- Someone who is divorced and has children.
- Someone who has been married more than once.
- Someone who is single and has assets that he or she want distributed according to his or her wishes.

If all the above sounds like everybody then you're right.

Every adult that has accumulated some assets needs to have a will so they can define what will happen to their assets when they die.

What about Will Kits?
You can find simple will kits in bookstores and on the Internet and they are legal and cheap. Something that is simple and inexpensive has limitations in what it can do for you. If you want to take the simple will kit and try and tailor it to your needs you may find it difficult to work with over time. The value of your time may make the will kit more expensive in the long run when compared to working with a lawyer who can make you a will very quickly.
**Trusts**

People often associate trust funds only with the wealthy. But a trust fund ("trust") actually can be an effective financial tool for many people in many circumstances. A trust is a separate legal entity that holds property or assets of some kind for the benefit of a specific person, group of people or organization known as the beneficiary (or beneficiaries). The person creating a trust is called the grantor, donor or settlor.

When a trust is established, an individual or corporate entity is designated to oversee or manage the assets in the trust. This individual or entity is called a trustee. A trustee can be a professional with financial knowledge, a relative or loyal friend or a corporation. There are pluses and minuses to each type of trustee. An individual trustee may provide a more personal touch, but may die or move away. A corporate trustee may be less personal but provides experience, investment skills, permanence and impartiality. More than one trustee can be named by the grantor if he or she wishes.

**Benefits of Establishing a Trust**

Whether it makes sense to establish a trust depends on your individual circumstances. Some common reasons for setting up a trust include:

- To provide for minor children or family members who lack financial experience or who are unable to manage their assets;
- To provide for management of your assets should you become unable to oversee them yourself;
- To avoid probate and transfer your assets immediately to your beneficiaries upon death;
- To reduce estate taxes or provide liquid assets to help pay for them.

Keep in mind that you may not need to establish a trust to accomplish these and other financial goals. A will may distribute your assets appropriately. Check with a lawyer before deciding if a trust is right for you.

**Types of Trusts**

There are two basic forms of trusts: after-death (or testamentary) and living (or inter vivos).

An **after-death trust** will come into existence, usually by virtue of a will, after a person's death. The assets to fund these trusts must usually go through the probate process. In certain states they may be court-supervised even after the estate is closed. An example of an after-death trust would be a parent leaving money to a trust benefiting a young son in her will. The will establishes the trust to which the land is transferred, to be administered by a trustee until the boy reaches a stated age (age 21), at which point the money is transferred to the son outright.

A **living trust**, on the other hand, is a trust made while the person establishing the trust is still alive. In this case, a mother could establish a trust for her son during her lifetime, designating herself as trustee and her son as beneficiary. As the beneficiary, her son does not own the property but can receive income derived from it.
Probate-Avoiding Living Trusts

Ask people why they work hard and save their money, and often you'll hear that it's not only because they want to raise their own standard of living; they want to leave something behind for their children, too. Understandably, they don't want a big chunk of that money to be used up for probate lawyers' fees.

That's where living trusts come in. They don't save you a penny while you're alive, but after death they can eliminate the need for probate -- and probate fees. (Probate involves inventorying and appraising the property, paying debts and taxes, and distributing the remainder of the property according to the will.) When you make a living trust -- a device in which you hold property as a "trustee" -- your surviving family members can transfer your property quickly and easily, without probate. More of the property you leave goes to the people you want to inherit it.

Types of Living Trusts

The two most common types of living trusts are:

- a basic living trust (for an individual or couple), which avoids probate, and
- an AB trust, which both avoids probate and saves on estate tax.

Unless you expect to owe federal estate tax at your death or your spouse's, a basic living trust to avoid probate is probably all the trust you need. (Only about 2% of estates -- those worth more than $2.0 million -- owe estate tax. Note until 2011, the amount of your estate not subject to tax increases.) [Check the NEA Retired website for updated information.]

Probate-Avoidance Living Trusts

A basic living trust allows property to avoid probate and to quickly and efficiently pass to the beneficiaries you name, without the hassles and expense of probate court proceedings. A married couple can use one basic living trust to handle both co-owned property and the separate property of either spouse.

Creating a Trust

To create a basic living trust, you make a document called a declaration of trust, which is similar to a will. You name yourself as trustee -- the person in charge of the trust property. Then you transfer ownership of some or all of your property to yourself in your capacity as trustee. For example, you might sign a deed transferring your house from yourself to yourself "as trustee of the Jane Smith Revocable Living Trust dated July 12, 2002."

Because you're the trustee, you don't give up any control over the property you put in trust. If you and your spouse create a trust together, you will be co-trustees.

In the declaration of trust document, you name the people or organizations you want to inherit trust property after your death. You can change those choices if you wish; you can also revoke the trust at any time.
After You Die

When you die, the person you named in the trust document to take over -- called the successor trustee -- transfers ownership of trust property to the people you want to get it. In most cases, the successor trustee can handle the whole thing in a few weeks with some simple paperwork. No probate court proceedings are required.

Do You Need a Lawyer to Create a Trust?

Trusts take about as much time to create as do wills. If your circumstances are not complicated, investing a couple of hours of your time using an estate planning book or software will help you understand the type of trust and trust structure which will best meet your needs. However, since most trusts deal with issues concerning taxation and estate planning, we recommend consulting with a professional and having your trust drawn up by an attorney who understands your situation and goals in establishing the trust.

Supplemental (Special) Needs Trusts

The term, “special needs trust,” is used in a general sense to describe one or more types of trusts that can be used to provide financial support to an adult with special needs without affecting the adult’s eligibility for Medicaid and other government programs. Some special needs trusts are creatures of state law, while others are authorized by federal law.
Power of Attorney

No estate plan is complete without a durable power of attorney. For most people, a power of attorney is used in case of illness when the person granting the power is no longer able to think and reason independently.

Giving someone, even a family member, your power of attorney is a serious legal action. When you give a relative or friend your power of attorney (referred to as a general power of attorney) you transfer your right to do anything with you and your assets. Ask yourself these questions when deciding on a power of attorney:

1. Who will represent my interest and me if I were incapable to make those decisions?
2. Who do I trust with my life and my money?
3. Is the person I’m thinking about reliable?
4. Does this person know me and my wishes?
5. Does this person have the same values that I have?

There are several types of powers of attorney. In addition to an unlimited power of attorney, you may give an attorney a limited power of attorney to close a mortgage loan for you. In the case of illness you may give someone a medical power of attorney to make healthcare decisions about your medical treatment if you’re incapable of making those decisions.

You can also give an individual or an institution a power of attorney to act for you after you die. The giving of a power attorney to someone or institution is a very serious matter and should not be done until you give it careful consideration and discussion. A power of attorney should be reviewed on a regular basis and, if necessary, updated or changed.

Always consult with your personal/family lawyer in the development of a power of attorney.
**Estate Taxes**

A primary purpose of estate planning is to distribute your assets according to your wishes after your death. Successful estate planning transfers your assets to your beneficiaries quickly and usually with minimal tax consequences. The process of estate planning includes inventorying your assets and making a will and/or establishing a trust, often with an emphasis on minimizing taxes.

**Do I Need to Worry?**

Adding up the value of your assets can be an eye-opening experience. By the time you account for your home, investments, retirement savings and life insurance policies you own, you may find your estate in the taxable category.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EXCLUSION AMOUNT</th>
<th>HIGHEST ESTATE TAX RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$3.5 million</td>
<td>45%</td>
</tr>
<tr>
<td>2010</td>
<td>Tax Repeal</td>
<td>0</td>
</tr>
<tr>
<td>2011+</td>
<td>$1 million</td>
<td>50%</td>
</tr>
</tbody>
</table>

Even if your estate is not likely to be subject to federal estate taxes, estate planning may be necessary to be sure your intentions for disposition of your assets are carried out.

**Taking Stock**

The first step in estate planning is to inventory everything you own and assign a value to each asset. Here’s a list to get you started. You may need to delete some categories or add others.

- Residence
- Other real estate
- Savings (bank accounts, CDs, money markets)
- Investments (stocks, bonds, mutual funds)
- 403(b), 401(k), IRA, pension and other retirement accounts
- Life insurance policies and annuities
- Ownership interest in a business
- Motor vehicles (cars, boats, planes)
- Jewelry
- Other personal property

Once you've estimated the value of your estate, you're ready to do some planning. Keep in mind that estate planning is not a one-time job.
How Estates Are Taxed

Federal gift and estate tax law permits each taxpayer to transfer a certain amount of assets free from tax during his or her lifetime or at death. (In addition, as discussed in the next section, certain gifts valued at $13,000 or less can be made that are not counted against this amount.) The amount of money that can be shielded from federal estate or gift taxes is determined by the federal unified tax credit. The credit is used during your lifetime when you make certain taxable gifts, and the balance, if any, can be used by your estate after your death.

Keep in mind that while you can plan to minimize taxes, your estate may still have to pay some federal estate taxes. What's more, your estate may be subject to state estate or inheritance taxes, which are beyond the scope of this pamphlet. An estate planning professional can provide more information regarding state taxes.

Minimizing Estate Taxation

There are a number of estate planning methods that can be used to minimize federal taxes on your estate.

- Giving away assets during your lifetime. Federal tax law generally allows each individual to give up to $13,000 per year to anyone without paying gift taxes, subject to certain restrictions. [Check the NEA Retired website for updated information.] That means you can transfer some of your wealth to your children or others during your lifetime to reduce your taxable estate. For example, you could give $13,000 a year to each of your children, and your spouse could do likewise (for a total of $26,000 per year to each child). You may make $11,000 annual gifts to as many people as you wish. You may also give your child or another person more than $11,000 a year without having to pay federal gift taxes, but the excess amount will count against the amount shielded from tax by your unified credit. For example, if you gave your favorite niece $30,000 a year for the last three years, you would have reduced your unified credit by $60,000 (a $20,000 excess gift each year).

- The marital deduction shields property transferred to a spouse from taxes. Federal tax law generally permits you to transfer assets to your spouse without incurring gift or estate taxes, regardless of the amount. This is not, however, without its drawbacks. Marital deductions may increase the total combined federal estate tax liability of the spouses upon the subsequent death of the surviving spouse. To avoid this problem, many couples choose to establish a bypass trust.

- Bypass trusts or credit shelter trusts can give a couple the advantages of the marital deduction while utilizing the unified credit to its fullest. With a bypass or credit shelter trust, the first spouse to die can leave the amount shielded by the unified credit to the trust. The trust can provide income to the surviving spouse for life, then upon the death of the surviving spouse the assets are distributed to beneficiaries, such as children. This permits the spouse who dies first to fully utilize his or her unified credit. If the trust document is drawn properly, the assets in the trust are not included in the surviving spouse's estate. Thus, the surviving spouse's estate will be smaller and can also utilize the unified credit.
Charitable gifts are not taxed as long as the contribution is made to an organization that operates for religious, charitable or educational purposes. Check to see if the organization you want to give money to is an eligible charity in the eyes of the Internal Revenue Service. You, or your estate may be entitled to a tax deduction for contributions to a qualifying charity. Consult your tax advisor.

Estate planning is very complex and is subject to changing laws. Be sure to seek professional advice from a qualified attorney, and perhaps a CPA or estate planner. The money you spend now to plan your estate can mean more money for your beneficiaries in the long run.

**Will my estate have to pay taxes after I die?**

It depends. The federal government imposes estate tax at your death only if your property is worth more than a certain amount, which depends on the year of death. But all property left to a spouse is exempt from the tax, as long as the spouse is a U.S. citizen. Estate tax is also not assessed on any property you leave to a tax-exempt charity.

<table>
<thead>
<tr>
<th>Year of Death</th>
<th>Exempt Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$3.5 million</td>
</tr>
<tr>
<td>2010</td>
<td>No estate tax</td>
</tr>
<tr>
<td>2011</td>
<td>$1 million unless Congress extends repeal</td>
</tr>
</tbody>
</table>

Special rules apply to certain estates that contain family-owned businesses and farms, which may receive a special $1.3 million exclusion from estate tax. The rules for qualifying are complex; consult an estate planning specialist if you're interested.

**Can't I just give all my property away before I die and avoid estate taxes?**

No. The government long anticipated this one. If you give away more than $13,000 per year to any one person or non-charitable institution, you are assessed federal "gift tax," which applies at the same rate as the estate tax. [Check the NEA Retired website for updated information.]

Making gifts of less than $13,000, however, can yield substantial estate tax savings if you keep at it for several years. Some other kinds of gifts are exempt from the gift/estate tax as well. You can give an unlimited amount of property to your spouse, unless your spouse is not a U.S. citizen, in which case you can give away up to $134,000 per year free of gift tax. Any property given to a tax-exempt charity avoids federal gift taxes. And money spent directly for someone's medical bills or school tuition is exempt as well.

**Do some states impose death taxes?**

Most states have effectively abolished a separate state death tax. A handful of states still impose tax on:

- all real estate owned in the state, no matter where the deceased person lived, and
• all property of residents of the state, no matter where it's located.

• In most states that still impose a separate tax on a deceased person's property, it is called an inheritance tax. In a few others, it's called an estate tax. Although theoretically different -- one's a tax on the person who inherits, the other a tax on the estate itself -- the result is the same. The tax is usually paid from the deceased person's property.

**States That Impose a Separate Death Tax**

- Indiana
- Iowa
- Kentucky
- Louisiana
- Maryland
- Nebraska (county inheritance tax only)
- New Hampshire
- New Jersey
- Ohio
- Oklahoma
- Pennsylvania
- Tennessee

States not listed above use what's called a "pick-up" tax. Using this type of tax, the state claims a share of any federal estate tax paid by an estate. This pick-up tax is a matter for accountants and tax preparers (a state death tax return must be prepared), but it doesn't increase the tax bill for inheritors.

**Can I avoid paying state death taxes?**

If your state imposes death taxes, there probably isn't much you can do. But if you live in two states -- winter here, summer there -- your inheritors may save on death taxes if you can make your legal residence in the state with lower, or no, death taxes.
Charitable Trust

If you want to make a substantial gift to a charity, it may make sense to explore using a special kind of trust, called a charitable trust. It lets you donate generously to charity, and it gives you and your heirs a big tax break.

On the other hand, if you just want to leave property to family or friends and make a few minor charitable gifts, then a charitable trust probably isn't worth the bother.

In any case, you need to do some serious thinking before setting up a charitable trust. Charitable trusts are irrevocable. Once you create one and it becomes operational, you cannot change your mind and regain legal control of the trust property.

How It Works

The most common type of charitable trust is called a charitable remainder trust. Here's how it usually works: first, you set up a trust and transfer to it the property you want to donate to a charity. The charity must be approved by the IRS, which usually means it has tax-exempt status under the Internal Revenue Code. (You can ask the IRS whether or not a particular charity is eligible.)

The charity serves as trustee of the trust, and manages or invests the property so it will produce income for you. The charity pays you (or someone else you name) a portion of the income generated by the trust property for a certain number of years, or for your whole life. You specify the payment period in the trust document. Then, at your death or the end of the period you set, the property goes to the charity.

What's in It for You

In addition to helping out your favorite charity, you get several big tax advantages from this arrangement.

Income Tax

You can take an income tax deduction, over five years, for the value of your gift to the charity. Where things get tricky is determining the amount of your deduction. The value of your gift is not simply the value of the property; the IRS deducts from that value the amount of income you're likely to receive from the property. For example, if you donate $100,000 but can expect (based on your life expectancy, interest rates and how the trust document is set up) to get $25,000 in income back, the value of your gift is $75,000.

Estate Tax

When the trust property eventually goes to the charity outright (at your death or the end of the payment period you specified), it's no longer in your estate -- so it isn't subject to federal estate tax. (Most people don't need to worry about estate tax, however, which is assessed only on large estates.)

Capital Gain Tax

One of the most desirable aspects of a charitable trust is that it lets you turn appreciated property (property that has gone up significantly in value since you acquired it) into cash without paying tax on the profit. If you simply sold the property, you would have to pay
capital gains tax on your profit. But charities, unlike individuals, don't have to pay capital gains tax. So if you give the property to the trust and the charity sells it, the proceeds stay in the trust and aren't taxed.

A charity usually sells any non-income-producing asset in a charitable trust and uses the proceeds to buy property that will produce income for you. For example, Margaret owns stock worth $300,000. She paid $20,000 for it 20 years ago. She creates a charitable trust, naming the Susan G. Koman Breast Cancer Foundation as the charity beneficiary, and funds her trust with her stock. The Foundation sells the stock for $300,000 and invests the money in a mutual fund. Margaret will receive income from this $300,000 for her life.

Had Margaret sold the stock herself, she would have had to pay capital gains tax on her $280,000 profit. But no capital gain tax is assessed against the Susan G. Koman Breast Cancer Foundation.

Income for You

When you set up a charitable remainder trust, there are two basic ways to structure the payments you will receive.

Fixed Annuity

You can receive a fixed dollar amount (an annuity) each year. That way, if the trust has lower-than-expected income, you still receive the same annual income. Once you set the amount and the trust is operational, you can't change it. Theoretically, you can make the payments as high as you want. Practically, however, there are limits:

1. First, the higher the payments, the lower your income tax deduction.
2. Second, high payments might eat into principal, possibly even using it all up before the payment term is over and leaving nothing for the charity.
3. Third, a charity is unlikely to accept a gift if it is likely, or even possible, that all the trust property will be paid back to you.

Percentage of Trust Assets

It's common to set your annual payment as a percentage of the value of the current worth of the trust property. For example, your trust document could specify that you will receive 7 percent of the value of the trust assets yearly. Each year the trust assets will be reappraised, and you will receive 7 percent of that amount.

Because you receive a percentage, not a flat dollar amount, if inflation (or wise investment) pushes up the dollar value of the assets, your payments go up accordingly. Under IRS rules, you must receive at least 5 percent of the value of the trust each year.
Making the Most of a Charitable Trust

Jack, age 60, earns a very comfortable salary and has assets worth $3 million, including stock that he bought years ago for $400,000. The stock has appreciated enormously -- it's now worth $1.6 million -- but pays very little in dividends.

If Jack sold the stock and bought income-producing assets, he would owe capital gains tax of $240,000. Instead, he sets up a charitable remainder trust with his alma mater as the charitable beneficiary. Jack funds the trust with the stock.

For income tax purposes, his donation to the charity is the full market value of the stock, less the amount Jack is likely to receive, based on his age and current interest rates. He takes this amount as a tax deduction over five years.

The charity, as trustee, sells the stock and receives a profit of $1.2 million, which is not taxed. The trustee reinvests this entire amount into a well-paying investment. The trust document requires Jack to be paid 6% of the trust value annually for life. This figure will be $72,600 the first year; it will change each year as the value of trust assets changes.

So far, Jack has avoided paying capital gains tax and turned an asset that paid little income into one that pays much more. But there is even more good news. Jack has also reduced his estate, and consequently the estate tax that will be due at his death. Jack has given money to the school instead of to Uncle Sam. And he has a guaranteed income for life.

If Jack lives 20 more years, the trust will pay him at least $72,600 \times 20, or $1,452,000. If the trustee invests the original $1.6 million wisely, it -- and the payments to Jack -- should also increase significantly.

Pooled Income Trusts

Another kind of charitable trust is the pooled income trust, which allows people of more modest means to take advantage of charitable tax deductions, donate to a favorite charity and receive an income for life.
V. SURVIVORSHIP

Everyone has that “special place” at home where all the important papers are kept, neatly organized in file folders, clearly labeled and understandable should the unfortunate occur. Or do we? Furnishing survivors with a detailed record of up-to-date legal, financial, and personal information in your absence will help alleviate added emotional and financial strain during what is often a painful and difficult time.

The guide is not intended to replace professional estate and legal counseling and you should feel free to customize or modify the guide to suit your family's unique circumstances. Once you complete all applicable information, we recommend you store the guide in a secure, accessible place. A safe deposit box, for instance, does not offer immediate accessibility. For extra peace of mind, tell loved ones, relatives or friends where the guide is stored. It's a good idea to continually review your financial situation and update the information you've recorded in the guide.

Inventory List

To assist your survivors in locating important papers and documents in the event of your death, we suggest you review the items listed below and record the location of only those items that apply to you.

<table>
<thead>
<tr>
<th>Birth Certificate</th>
<th>Marriage Certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank Statements</td>
<td>Insurance Policies</td>
</tr>
<tr>
<td>Loan Documents</td>
<td>Personal Phone Book</td>
</tr>
<tr>
<td>Credit Card Statements</td>
<td>Safe Deposit Box</td>
</tr>
<tr>
<td>Investment Information</td>
<td>Social Security Statements</td>
</tr>
<tr>
<td>Tax Returns</td>
<td>Real Estate Deeds</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Vehicle Titles</td>
</tr>
<tr>
<td>Wills/Trust</td>
<td>Living Will</td>
</tr>
<tr>
<td>Legal Papers</td>
<td>Military Records</td>
</tr>
</tbody>
</table>
RECORDKEEPING

Personal documents, household records and important legal papers accumulate continually. A recordkeeping system will help you organize the important records concerning your household financial affairs and keep track of your personal finances and hard-to-replace documents. Another benefit to having all of your tax records and documents in a designated place is you can efficiently prepare your tax returns.

Recordkeeping can help you save time and money while giving you peace of mind. Keeping orderly records will help you locate payment documentation when required, such as to prove payment of child support or medical bills to insurance companies, or to obtain warranty coverage. You can also document losses for fire damage or theft for insurance claims.

Setting up a recordkeeping system involves three steps:

I. Gather and organize financial records.

II. Decide where each type of record should be kept -- in a home file or safe deposit box.

III. Review and discard unneeded paperwork.

Organize Financial Information

Organizing important personal records will make money management easier for you and for others who may be responsible for handling your financial affairs. When you organize financial papers, the first step is to locate all of the documents and related information such as phone and account numbers. Gather information in categories such as:

- **Legal**: Wills, living wills, powers of attorney, donor information, estate planning documents, death certificates, adoption papers, citizenship papers, military service records, and Social Security cards.
- **Medical**: Physician and dentist information, current prescriptions, allergy information, doctor/hospital bills, insurance cards.
- **Life & Health**: Copies of policies for term life, whole life, employer-provided health care, individual health care, Medicare, and Medicaid.
- **Auto/Home**: Copies of policies for auto casualty/liability, personal property, declaration sheets, homeowners/renters, claim records/numbers, agent information, flood/earthquake.
- **Banking**: Bank accounts, check registers, bank locations/contact names, safe deposit box numbers/keys, money market accounts, certificate of deposits.
- **Retirement**: State pensions, annuities (403b), individual retirement accounts, stocks/mutual funds, government bonds, Social Security payments, total assets.
- **Personal Expenses**: Store charge cards, bank credit/debit cards, school/auto loans, closed account confirmation letters, rent payments, warranties.
• **Personal Valuables.** Certificates, appraisals, and photographs of antiques, jewelry, art/photographs, family heirlooms, rare books, recordings, china/crystal, other collections.

• **Real Estate.** Architectural drawings/floor plans, deeds, block/lot numbers, home/termite inspections, mortgages/contracts, land surveys, title insurance, tax assessments.

• **Titles and Certificates.** Property/vehicle titles, birth/marriage certificates, passports, legalization papers, children’s documents, pet licenses.

**Storing Financial Records**

Financial records can be kept either in a home file or in a safe-deposit box at a financial institution. Active records (those used on a regular basis) and those of limited value can be kept in a home file. Select a convenient place such as in the kitchen or home office area to keep important household financial documents. A file cabinet that is fire and water resistant makes good sense. Or you can simply use an inexpensive cardboard box that holds file folders. Keep it handy, where it can be accessed easily, probably not on the top shelf of the closet. Consider using a safe-deposit box to store records that would be difficult to replace (such as those in the following categories: Legal, Personal Valuables, and Titles and Certificates).

At least one other person should know where your important records are kept and how they are organized, so in an emergency that person can locate information quickly. A logical place to keep this information would be at the front of the active files. The information should include a list of items in the safe-deposit box and where the key is located.

**Review and Discard Unneeded Records**

You will accumulate many financial papers over time, so it is important to know which to keep and for how long. You should keep the following documents:

• **3 Years:** Household bills (paid and unpaid); receipts for minor purchases; health records; and income tax receipts.

• **7 Years:** Cancelled checks; check registers; bank statements; bank deposit slips; year-end pay stubs; credit-card statements; receipts and records of deductible expenses; income and tax paperwork (some financial advisors suggest that you keep a copy of your tax returns with documentation for at least 10 years). In addition, investment purchase and sale records should be kept for seven years after the tax deadline for the year of sale.

• **Permanently:** Personal records that provide documentation of events such as birth, marriage, divorce, death, military service, adoption, naturalization and medical records. Also, housing and investment records such as titles, deeds, trust agreements, wills, retirement plan agreements, and power of attorney documents should be kept as long as the agreements are in effect. For tax purposes, papers documenting home purchase and improvements should be kept as long as you own the property or are rolling over profits into new property.
For those records that you decide to discard, it’s in your best interest to shred them. You can purchase a shredder at most office supply or discount retailers. Make sure the shredder is a “cross-cut” model and has a credit card slot.
LETTER OF INSTRUCTIONS

If you have drawn up a proper will, a health care proxy, and a durable power of attorney, you need to consider an additional document: a letter of instructions. The letter is personal. It contains guidelines and information to help family members cope with decisions that need to be made shortly following your death.

How does the letter of instructions differ from a will? A will, at the event of your passing, may not be read for several days. But a letter of instructions would be available immediately to guide your survivors in the hours and days after death.

The letter can contain answers – in your own words – to questions such as these:

- Is there a memorial fund (or funds) for designated contributions?
- How can personal financial records be found?
- Where is the safe deposit key? What are the contents of the deposit box?
- How should personal items be handled such as: school papers, job-related documents, memorabilia, genealogy charts, and collections?
- Are there computer files that have important information stored in memory?
- Where are important papers located? (Suggestion: be specific – note which filing cabinet and which drawer.)
- Where is the most current tax return? Where are other returns from recent years stored?

The Emotions of Writing the Letter

Composing a letter of instructions should not be viewed as a depressing task. Rather, it can be considered a positive step to help family members cope with decision-making in a stressful period. In writing the letter, you are providing a valuable, loving service to your survivors. It gives everyone some peace of mind.

Funeral Arrangements

Clearly, one of the most important sections in the letter should cover the sensitive issues surrounding your funeral. This part should contain your wishes about the kind of service preferred, whether body organs should be donated, disposition of the body, and other matters that your family will face in the hours after a death. Write down your birthplace and the names of your father, mother, sisters, and brothers. Include information about your education, employment history, honors received, volunteer leadership positions; and any military record that might apply. Provide reference to a funeral plot that may have been purchased, the deed number, and location.

Include the names of individuals who need to be notified upon your death. List telephone numbers and/or e-mail addresses for your circle of family, friends, and business colleagues.

Obituary

Who is the best person to highlight the accomplishments of your life – you! Preparing your own obituary will alleviate a difficult task of your loved ones. Most obituaries
include the location of your birth, highlights of your career history (including any special recognitions or educational accomplishments), and your surviving family members. Include a list of newspapers in which you would like to have your obituary published.

**Filing and Updating the Contents**

The letter should be filed in a place where family members have immediate access to its contents. Let your family know the whereabouts of the letter if you move it to a new location.

Most important, keep it updated! If you have access to a personal computer, save the letter for future revisions. Re-write sections of the letter when conditions change, when new financial decisions are made, or when your own personal views change.

It is unlikely that you will think about every important topic when the document is first composed. Anticipate that you will want to add more topics down the road — another reason to store the contents on a computer file.

**An Important Task for All Adults**

This task is not something that just retirees should consider. Every adult needs to have a letter of instructions prepared — no matter what age, wealth, or health. This could be one of the most important letters you will write in your entire lifetime! The document will take some time to complete, but it will be well worth the effort – knowing you have performed a real service to your loved ones.

**Questions**

Listed below are a series of questions - about you, about final arrangements, about your estate and about your finances. In cases where you are asked to list names, addresses and phone numbers, do so in the space provided.

**About You**

1. What is your:
   - Name
   - Date of Birth
   - Social Security #
2. Do you have a will or trust?
3. Who are the executor and alternate executor? List names, addresses, and phone numbers.
4. Who is your lawyer? List name, address, and phone number.
5. Who is your accountant/tax adviser? List name, address, and phone number.
6. Who are your banker/insurance/financial advisers? List names, addresses, and phone numbers.
7. Who are your doctor and dentist? List names, addresses, and phone numbers.
8. Who is your minister or religious adviser? List their name, address, and phone number.

About Final Arrangements

1. Have you made arrangements (i.e., a living will) regarding medical procedures in the event you become incapacitated?
2. Do you have a pre-paid (pre-arranged) funeral plan?
3. Have you made burial arrangements? If so, what is the name and location of the cemetery? What are the plot and deed numbers?
4. Have you discussed a budget for funeral and final expenses? If yes, where can instructions be found?
5. Do you have a preference concerning the disposition of your remains? If yes, provide instructions.
6. Do you wish to donate your organs? If yes, provide instructions or indicate where instructions are located.
7. Do you wish to have a memorial service? If yes, provide instructions.
8. Have you designated an organization to receive your memorial gifts? If yes, list the name and address of the organization(s).
9. Have you planned for the disposition of your personal belongings? If yes, provide instructions.

About Your Finances

1. What are your financial obligations? List mortgages, loans, and credit card balances.
2. Who owes you money? List location of loan documents, borrower’s name, address, phone number, date of loan, amount of loan, interest rate, and repayment schedule.
3. Do you have a stockbroker? List name(s), firm, address, phone number, and your account numbers.
4. Do you own stocks, bonds, mutual funds, CDs, real estate, or any other type of investment? If so, provide and list account information for each.
5. Who should notify your creditors upon your death? Does that individual have all the information needed to help you pay your bills?

Do You Need Help?

For additional assistance in preparing your will and estate planning, contact the NEA Attorney Referral Service (NEA Office of Legal Services) at 202-822-7080.
VI. IDENTITY THEFT

Between January and December 2008, Consumer Sentinel, the complaint database developed and maintained by the Federal Trade Commission (FTC), received over 1.2 million consumer fraud and identity theft complaints. Consumers reported losses from fraud of more than $1.8 billion.

The 1990's spawned a new variety of crooks called "identity thieves." An identity thief illegally obtains some piece of your sensitive information and uses it without your knowledge to commit fraud or theft.

Identity theft is a serious crime. People whose identities have been stolen can spend months or years - and thousands of dollars - cleaning up the mess identity thieves have made of their good name and credit record. Some victims have lost job opportunities, been refused loans for education, housing or cars, or even been arrested for crimes they didn't commit.

How Identity Theft Occurs

Skilled identity thieves use a variety of methods to gain access to your personal information. For example, they:

- Steal wallets and purses.
- Steal mail.
- Complete a "change of address form" to divert your mail to another location.
- Scam information from you by posing as a legitimate businessperson.

Once identity thieves have your personal information, they may:

- Go on spending sprees using your credit and debit card account numbers to buy "big-ticket" items like computers that they can easily sell.
- Open a new credit card account, using your name, date of birth and Social Security number.
- Take out auto loans in your name.
- Establish phone or wireless service in your name.
- Open a bank account in your name and write bad checks on that account.
- Give your name to the police during an arrest (If they are released and don't show up for their court date, an arrest warrant could be issued in your name.).

How Can I Tell if I'm a Victim of Identity Theft?

Indications of identity theft can be:

- Failing to receive bills or other mail signaling an address change by the identity thief.
- Receiving credit cards for which you did not apply.
- Denial of credit for no apparent reason.
- Receiving calls from debt collectors or companies about merchandise or services you didn't buy.
Order a copy of your credit report from each of the three major credit bureaus:

- Equifax. P.O. Box 740241, Atlanta, GA 30374-0241; 800-525-6285
- Experian. P.O. Box 9532, Allen, TX 75013; 888-EXPERIAN (397-3742)
- TransUnion. Fraud Victim Assistance Division, P.O. Box 6790, Fullerton, CA 92834; 800-680-7289

If it's accurate and includes only those activities you've authorized, chances are you're not a victim of identity theft. The law allows credit bureaus to charge you up to $9 for a copy of your credit report.

**Managing Your Personal Information**

So how can a responsible consumer minimize the risk of identity theft, as well as the potential for damage? When it involves your personal information, exercise caution and prudence.

Place passwords on your credit card, bank and phone accounts. Avoid using easily available information like your mother's maiden name, your birth date, the last four digits of your SSN or your phone number, or a series of consecutive numbers. When you're asked for your mother's maiden name on an application for a new account, try using a password instead.

Secure personal information in your home, especially if you have roommates, employ outside help, or are having service work done in your home.

Ask about information security procedures in your workplace. Find out who has access to your personal information and verify that your records are kept in a secure location. Ask about the disposal procedures for those records as well.

**Everyday Diligence**

Don't give out personal information on the phone, through the mail or over the Internet unless you've initiated the contact or are sure you know with whom you're dealing. Identity thieves are skilled liars and may pose as representatives of banks, Internet service providers (ISPs) or even government agencies. Before you divulge any personal information, confirm that you're dealing with a legitimate representative of a legitimate organization.

Guard your mail and trash from theft. Deposit outgoing mail in post office collection boxes or at your local post office instead of an unsecured mailbox. Remove mail from your mailbox promptly. If you're planning to be away from home and can't pick up your mail, call the U.S. Postal Service at 1-800-275-8777 to ask for a vacation hold. To thwart a thief who may pick through your trash or recycling bins, tear or shred your charge receipts, copies of credit applications or offers, insurance forms, physician statements, checks and bank statements, and expired charge cards.

Before revealing any identifying information (for example, on an application), ask how it will be used and secured, and whether it will be shared with others. Find out if you have a say about the use of your information. For example, can you choose to have it kept confidential?
Pay attention to your billing cycles. Follow up with creditors if your bills don't arrive on time. A missing credit card bill could mean an identity thief has taken over your account and changed your billing address.

**A Special Word About Social Security Numbers**

Very likely, your employer and financial institution will need your Social Security Number (SSN) for wage and tax reporting purposes. Other private businesses may ask you for your SSN to do a credit check, such as when you apply for a car loan. Sometimes, however, they simply want your SSN for general record keeping. If someone asks for your SSN, ask the following questions:

- Why do you need it?
- How will it be used?
- How do you protect it from being stolen?
- What will happen if I don’t give it to you?

If you don't provide your SSN, some businesses may not provide you with the service or benefit you want. Getting satisfactory answers to your questions will help you decide whether you want to share your SSN with the business.

**Consider Your Computer**

Your computer can be a goldmine of personal information to an identity thief. Here's how you can safeguard your computer and the personal information it stores:

- Update your virus protection software regularly. Computer viruses can have damaging effects, including introducing program code that causes your computer to send out files or other stored information. Look for security repairs and patches you can download from your operating system's Web site.
- Don't download files from strangers or click on hyperlinks from people you don't know. Opening a file could expose your system to a computer virus or a program that could hijack your modem.
- Use a firewall, especially if you have a high-speed or "always on" connection to the Internet. The firewall allows you to limit uninvited access to your computer.
- Use a secure browser - software that encrypts or scrambles information you send over the Internet - to guard the safety of your online transactions.
- Try not to store financial information on your laptop unless absolutely necessary. If you do, use a "strong" password - that is, a combination of letters (upper and lower case), numbers and symbols.
- Avoid using an automatic log-in feature that saves your user name and password; and always log off when you're finished.
- Delete any personal information stored on your computer before you dispose of it. Use a "wipe" utility program, which overwrites the entire hard drive and makes the files unrecoverable. In addition, remove the hard drive completely and dispose separately.
Read Web site privacy policies. They should answer questions about the access to and accuracy, security and control of personal information the sites collect, as well as how sensitive information will be used and whether it will be provided to third parties.

**IF YOUR IDENTITY HAS BEEN STOLEN**

Even if you've been very careful about keeping your personal information to yourself, an identity thief can still strike. If you suspect that your personal information has been used to commit fraud or theft, take the following four steps right away. Remember to follow up all calls in writing and send your letter by certified mail, return receipt requested, so you can document what the company received and when. Keep copies of everything for your files.

1. Contact the fraud departments of each of the three major credit bureaus. Tell them you're a victim of identity theft and ask them to place a "fraud alert," as well as a "victim statement," in your file. It's a signal to creditors to call you before they open any new accounts or change your existing accounts, and helps prevent an identity thief from opening additional accounts in your name. At the same time, order copies of your credit reports.

2. Close any accounts that have been tampered with or opened fraudulently. Credit accounts include all accounts with banks, credit card companies and other lenders, and phone companies, utilities, ISPs, and other service providers. If your checks have been stolen or misused, close the account and ask your bank to notify the appropriate check verification service.

3. File a report with your local police or the police in the community where the identity theft took place. Keep a copy of the report. You may need it to validate your claims to creditors.

4. File a complaint with the FTC. Visit [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) to file a complaint instantly, obtain a copy of the ID Theft Affidavit and get answers to frequently asked questions about identity theft. If you don't have access to the Internet, call the FTC's Identity Theft Hotline, toll-free, at 1-877-IDTHEFT (438-4338).

**IDENTITY THEFT AND ASSUMPTION DETERRENCE ACT OF 1998**

The Identity Theft and Assumption Deterrence Act makes it a federal crime when someone "knowingly transfers or uses, without lawful authority, a means of identification of another person with the intent to commit, or to aid or abet, any unlawful activity that constitutes a violation of federal law, or that constitutes a felony under any applicable state or local law."

Under the Act, a name or SSN is considered a "means of identification." So is a credit card number, cellular telephone electronic serial number or any other piece of information that may be used alone or in conjunction with other information to identify a specific individual.

Violations of the Act are investigated by federal law enforcement agencies, including the U.S. Secret Service, the FBI, the U.S. Postal Inspection Service, and the Social Security Administration’s Office of the Inspector General. Federal identity theft cases are prosecuted by the U.S. Department of Justice.
In most instances, a conviction for identity theft carries a maximum penalty of 15 years' imprisonment, a fine, and forfeiture of any personal property used or intended to be used to commit the crime. Pursuant to the Act, the U.S. Sentencing Commission has developed federal sentencing guidelines to provide appropriate penalties for those persons convicted of identity theft.

Schemes to commit identity theft or fraud also may involve violations of other statutes, such as credit card fraud, computer fraud, mail fraud, wire fraud, financial institution fraud, or Social Security fraud. Each of these federal offenses is a felony and carries substantial penalties—in some cases, as high as 30 years in prison as well as fines and criminal forfeiture.