

# University of California



# Medicare Factsheet for Employees and Retirees

Medicare is the federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). This factsheet explains when and how the UC-sponsored medical plans coordinate with Medicare.

Medicare has four parts:

1. **Medicare Part A (hospital insurance)** helps pay for care in a hospital and skilled nursing facility, home health care and hospice care. It is usually an entitlement with no monthly premium because you paid Medicare taxes while working. For additional information about how you may qualify through a spouse, former spouse, or deceased spouse, contact the Social Security Administration (1-800-772-1213) or visit their website (SSA.gov).
2. **Medicare Part B (medical insurance)** helps pay for doctors, outpatient hospital care and other medical services. Most people pay a monthly premium for Part B which is deducted from your Social Security benefit. If you are not receiving a Social Security pension, the Social Security Administration will bill you directly.
3. **Medicare Part C (Medicare Advantage)** is the term used to describe the coordination between Medicare and UC's HMO plans. Under this arrangement, you are required to assign your Medicare benefit to your HMO and to maintain that assignment. In return, your HMO will provide your benefits and will handle the coordination with Medicare. If you are enrolled in an HMO and would like more information on Medicare Advantage, please see pages 4–7 or visit Medicare's website (www.medicare.gov).
4. **Medicare Part D (prescription drug insurance)** helps cover the cost of prescription drugs. UC will automatically enroll you in the Part D portion of your Medicare plan. For more information on Medicare Part D, please see the information on page 2, or visit www.medicare.gov.

In some cases, the UC/employer contribution for a Medicare medical plan is more than the total premium cost. In that case, you may receive a reimbursement from UC which covers all or part of your Medicare Part B monthly premium.

## UC Enrollment Requirements for Retirees

If you are a University retiree enrolled in a UC-sponsored medical plan, UC requires you and your enrolled family members to enroll in Medicare Part B as soon as you become eligible for premium-free Medicare Part A, usually at age 65. **Failure to comply with this policy can result in the permanent loss of your UC-sponsored medical coverage.**

## Medicare Eligibility and Part B Enrollment

Medicare eligibility is determined by the Social Security Administration (SSA), not the University. Most people become eligible for Medicare

- At age 65, or,
- Before age 65, after receiving Social Security disability benefits for 24 months.

Medicare generally does not cover health services outside the U.S. Therefore, UC waives its requirement that you enroll in Medicare Part B while you live outside the U.S. If/when you return to the U.S., benefits under Medicare Part A are available to you and you are required to enroll in Part B. Medicare may charge a higher premium when you re-enroll.

UC will send you a packet of information regarding Medicare three months before your 65th birthday. This packet will include a *Medicare Declaration* form (UBEN 126), which you must complete and return to UC with a copy of your Medicare card or your Social Security denial letter. The packet will also include UC's *Universal Medicare Advantage* form and those enrolled in HMO plans must complete the form and return it to the plan.

For more information, see *Medicare & You*, the national Medicare handbook, available online at www.medicare.gov or from your local Social Security Administration office.

## Employees Age 65 or Older

If you do not retire and continue working at the University past age 65, you are not required to sign up for Medicare Part B if you are eligible for Medicare Part A premium-free. This is because federal law stipulates that your UC group employer plan will be your primary coverage. When you retire, you must immediately enroll in Medicare Part B.

## UC-Sponsored Medical Plans and Medicare Part D

UC has integrated Medicare Prescription Drug plans with each of the Medicare coordinated plans. If you are a retiree and are enrolled in Medicare, UC will automatically enroll you in the Part D portion of your plan. You do not need to purchase Part A from any other source.

In order to retain UC's medical coverage you must maintain enrollment in your UC plan's Medicare Prescription Drug (Part D) plan. If you cancel your UC-sponsored Part D plan with CMS or enroll in a non-UC prescription drug plan, University rules require that if a retiree is enrolled in a medical plan offering Part D that is sponsored by the University, the retiree cannot be enrolled in another non-UC Part D plan.

If you have insurance from another employer or retiree plan, you should contact them and inquire about their rules regarding your enrollment in Medicare Part D.

## Medicare Part D Notice of Creditable Coverage

All UC Medicare prescription drug plans provide at least a standard level of coverage set by Medicare.

UC retirees who have UC-sponsored medical insurance **do not need to enroll in a non-UC Medicare**

**Part D Prescription Drug plan. If necessary, your UC medical plan will automatically enroll you in Part D and you will not be charged any additional premium.**

In 2008, the University is introducing a new plan option through Blue Cross of California, the Blue Cross PPO Medicare without Prescription Drugs plan. This plan will allow UC retirees who are eligible to participate in another medical insurance program with Part D benefits offered by another employer to do so while maintaining enrollment in UC's retiree medical insurance program. This plan provides coverage for medical and hospitalization, but **no prescription drug coverage**. It is **not** considered "creditable coverage" under Medicare Part D.

## Creditable Coverage

The University of California has determined that the prescription drug coverage offered by all the UC-sponsored Medicare plans (Blue Cross PLUS, Blue Cross PPO, Core California, Health Net/Seniority Plus, Health Net Medicare COB, Health Net Private Fee-for-Service, High Option Supplement to Medicare, Kaiser Permanente CA/Senior Advantage, Kaiser Permanent Mid-Atlantic, Kaiser Umbrella, and WHA Care+ is considered creditable coverage.

This means the prescription drug coverage, on average, is expected to pay out at least as much as the standard Medicare Part D benefit.

Under Medicare rules, Medicare enrollees must maintain continuous Part D coverage or may risk paying more for Part D in the future. If you cancel or lose UC-sponsored medical coverage and do not enroll in another Medicare Part D plan, in the future you may face a late enrollment penalty when you do enroll in Medicare Part D coverage.

For additional details, visit: [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE (1-800-633-4227).

## If You Return to Work at the University

If you return to work at the University, please contact the UC Customer Service Center at 1-800-888-8267, because your retiree medical coverage may need to be suspended while you work at UC.

If you or your family members are covered by Medicare and you become eligible for UC employee medi-

cal coverage because of your rehired appointment, federal law requires that Medicare no longer be your primary payer. To comply with this federal regulation, you are required to enroll in the non-Medicare version of your plan with Medicare as the secondary payer, or opt-out of UC-sponsored medical coverage and have Medicare coverage only.

If eligible for UC employee medical coverage, your local Benefits Office or the person in your department who handles benefits will advise you on the impact of your appointment on your Medicare enrollment. Your premium will be deducted from your employee earnings and, in most cases, your premium will increase.

If you are receiving any Medicare Part B reimbursement, it will stop.

Note: If you are eligible for employee medical coverage as a result of returning to work at UC, you cannot cancel your Medicare Part B enrollment even though Medicare is a secondary payer.

**If your new UC employment excludes you from employee medical benefits (e.g., you are appointed by agreement, in a per diem appointment, or your appointment is for less than 43.75 percent time), your retiree benefits continue and Medicare remains the primary payer.**

## UC Medical Plans for Medicare Enrollees

The UC-sponsored medical program offers separate plans for Medicare enrollees. The Medicare version of your medical plan may have different benefits, services areas, and doctors than the non-Medicare version of the plan. The Medicare versions of the UC-sponsored plans are listed below:

Non-Medicare	Medicare
Blue Cross PLUS	Blue Cross PLUS w/ Medicare
Blue Cross PPO	Blue Cross PPO w/Medicare PPO Medicare without Rx
CIGNA Choice Fund	Not available
Core	Core w/Medicare
Health Net HMO	Health Net Seniority Plus Health Net Medicare Coordination of Benefits
Health Net Primary EPO	Health Net Medicare Private Fee-for-service
Not available	High Option Supplement to Medicare
Kaiser CA	Kaiser CA Senior Advantage
Kaiser Mid-Atlantic	Kaiser Mid-Atlantic Medicare Plus
Kaiser Umbrella	Kaiser Umbrella Medicare Cost
WHA	WHA Care+

### Medicare Providers Required

To receive plan benefits under all UC-sponsored Medicare plans, you must use a provider who accepts Medicare. If your doctor does not take Medicare patients or will only render services under a “private contract” directly with you, neither Medicare nor your UC-sponsored medical plan will cover the services.

If your doctor takes non-Medicare patients but not Medicare patients, you may need to select a new doctor when you become eligible for Medicare.

### Service Areas May Differ

Some Medicare plans have a different service area than the non-Medicare version of the plan. If your plan requires that you live within the service area of the plan, and the Medicare version of the plan is not available where you live, then you and your family will be allowed to transfer to any UC-sponsored plan available in your area.

### Medicare Eligibility Does Not Create a PIE

Generally, becoming eligible for Medicare will not create a period of initial eligibility (PIE) to change plans. You will be automatically transferred to the Medicare version of your current plan. You can change plans only during Open Enrollment (or if you have another qualifying event) except if you are enrolled in the CIGNA Choice Fund. The CIGNA Choice Fund does not have a Medicare version; therefore, you will be able to select a new plan when you become eligible for Medicare.

### Medicare Assignment Paperwork May Be Required

The Health Net, Kaiser, and WHA plans require you to complete the *Medicare Advantage Universal Enrollment* form before your Medicare coverage (and reduced monthly cost) will be effective. Return this form directly to the plan prior to becoming eligible for Medicare.

# How Medicare Works with UC Medical Plans

## Health Net, Kaiser–CA, Western Health Advantage

If you are enrolled in a Health Net, Kaiser–CA, or Western Health Advantage plan, you assign your Medicare benefits to the plan by completing the *Universal Medicare Advantage* form and mailing it to the plan (the address is on the form). Medicare pays a flat fee to the plan each month, and the HMO agrees to assume full responsibility for your care.

## Blue Cross PLUS, Blue Cross PPO, High Option Supplement to Medicare, Core, and PPO Medicare Without Prescription Drugs

With these plans, you do not assign your Medicare benefits to the plan. When you receive services, Medicare is the primary payer, and the plan is secondary.

The **Blue Cross PLUS** plan offers two levels of coverage. The “in-network” level works like an HMO; you must coordinate all services through your primary care provider (PCP), and you pay a copayment each time you receive services. Unlike the HMO plans, however, Blue Cross PLUS also allows you to see Medicare providers that are not within your medical group. In this case, the service is covered at the lower “out-of-network” benefit level. In most cases, Medicare’s benefit will exceed Blue Cross’ benefit. As a result, Blue Cross Plus out-of-network benefits will rarely pay benefits in addition to Medicare.

With **Blue Cross PPO, Core, PPO Medicare Without Prescription Drugs, and High Option Supplement to Medicare**, you may see any Medicare provider. If your Medicare provider “accepts assignment,” he/she will accept the Medicare-approved rate for services. However, if your provider does not accept Medicare assignment, he/she can bill you for up to 15 percent over the Medicare allowable rate. This is called “balance billing.”

## What You Pay for Services

The following charts give some examples of what you might expect to pay for certain medical services. These are examples; your actual costs, coverage and payments may be different. For more information, see your medical plan’s Evidence of Coverage booklet.

Plan	Hospitalization
<b>Health Net/Seniority Plus Health Net Medicare COB Health Net Medicare Private Fee-for-Service Western Health Advantage/ WHA Care+ Kaiser/Senior Advantage</b>	You pay \$250 copay per occurrence or admittance. Medicare and plan pay the rest.
<b>Blue Cross PLUS In-Network<sup>1</sup></b>	You pay \$250 copay per admittance. Medicare and plan pay the rest for covered services.
<b>Out-of-Network<sup>1</sup></b>	Blue Cross will process payment according to the contract benefits, apply the plan’s deductible and pay any remaining allowable expenses at 70% then subtract Medicare’s payment. Blue Cross will pay the difference up to a maximum of what is allowed by Medicare (if the provider accepts assignment).
<b>Blue Cross PPO<sup>1</sup></b>	For the first 60 days, you pay 20% and the plan pays 80% of the Medicare Hospitalization Deductible. Medicare pays the remaining balance. For days 61–150, you pay 20% and the plan pays 80% of the daily Medicare coinsurance; Medicare pays the remaining balance. For days beyond 150, you pay 20%, plan pays 80%.
<b>Core<sup>1</sup></b>	For the first 60 days, you pay 20% and the plan pays 80% of the Medicare Hospitalization Deductible. Medicare pays the remaining balance. For days 61–150, you pay 20% and the plan pays 80% of the daily Medicare coinsurance; Medicare pays the remaining balance. For days beyond 150, you pay 20%, plan pays 80%.
<b>High Option Supplement to Medicare<sup>1</sup></b>	You pay nothing. Plan and Medicare pay 100%.
<b>PPO Medicare without Prescription Drugs<sup>3</sup></b>	For the first 60 days, you pay 20% and the plan pays 80% of the Medicare Hospitalization Deductible. Medicare pays the remaining balance. For days 61–150, you pay 20% and the plan pays 80% of the daily Medicare coinsurance; Medicare pays the remaining balance. For days beyond 150, you pay 20%, plan pays 80%.

1 Core, Blue Cross PLUS, Blue Cross PPO and High Option Supplement to Medicare assignment. After you meet your annual out-of-pocket maximum, your payment may be higher than the Medicare allowable amount. If your doctor does not accept Medicare assignment, you may be responsible for the difference.

2 Does not apply if your permanent address is outside the U.S.

3 Retirees may enroll in this plan only if: all family members have Medicare, and all family members are enrolled in another Medicare Part D prescription drug plan.

Doctor Visit	Emergency	Prescription Drug Copay Generic/Brand/Nonformulary	Medical Services when Traveling outside of U.S. <sup>2</sup>								
<p>You pay \$15 copay; Medicare and plan pay the rest</p>	<p>You pay \$50 copay (waived if admitted) (Health Net/Medicare HMO &amp; Medicare COB: \$15 copay if PPG-owned/operated); Medicare and plan pay the balance</p>	<p>Retail (30-day supply): \$10/\$20/\$35. Mail order: \$20/\$40/\$70. Kaiser: Retail (up to 100-day supply): \$10/\$20; Mail order: refills can be arranged.</p>	<p>Emergencies/urgent care covered. (PCP/HMO must be notified, you may need to file for reimbursement.) For other services you pay full costs: plan and Medicare do not pay.</p>								
<p>You pay \$20 copay; Medicare and plan pay the rest for covered services.</p> <p>Medicare pays 80% of Medicare allowable; plan pays benefits at 70%. If that benefit is greater than Medicare, plan pays the difference. In most cases the plan pays nothing.</p> <p>Example:<sup>1</sup></p> <table border="0" data-bbox="138 829 487 945"> <tr><td>Medicare allowable:</td><td>\$150</td></tr> <tr><td>Medicare pays 80%:</td><td>\$120</td></tr> <tr><td>Plan pays:</td><td>\$0</td></tr> <tr><td>You pay:</td><td>\$30</td></tr> </table>	Medicare allowable:	\$150	Medicare pays 80%:	\$120	Plan pays:	\$0	You pay:	\$30	<p>You pay \$75 copay (waived if admitted); Medicare and plan pay the balance</p> <p>You pay \$75 copay (waived if admitted); Medicare and plan pay the balance</p>	<p>Retail (30-day supply): \$15/\$25/\$40. Mail order (90-day supply): \$30/\$50/\$80.</p> <p>At participating pharmacies: Retail (30-day supply): \$15/\$25/\$40. Mail order (90-day supply): \$30/\$50/\$80. (Must use plan mail order facility.)</p>	<p>Emergencies/urgent care covered at 100%. (PCP must be notified, you pay copay.) Other services covered as out-of-network.</p> <p>You pay 30% of billed charges after deductible.</p>
Medicare allowable:	\$150										
Medicare pays 80%:	\$120										
Plan pays:	\$0										
You pay:	\$30										
<p>Medicare pays 80% of Medicare allowable; plan pays 80% of the balance; you pay any remaining balance.</p> <p>Example:<sup>1</sup></p> <table border="0" data-bbox="138 1018 487 1134"> <tr><td>Medicare allowable:</td><td>\$150</td></tr> <tr><td>Medicare pays 80%:</td><td>\$120</td></tr> <tr><td>Plan pays 80% of balance:</td><td>\$24</td></tr> <tr><td>You pay:</td><td>\$6</td></tr> </table>	Medicare allowable:	\$150	Medicare pays 80%:	\$120	Plan pays 80% of balance:	\$24	You pay:	\$6	<p>Medicare pays 80%, then plan pays 80% of the balance; you pay the amount remaining</p>	<p>Retail (30-day supply): \$15/\$25/\$40. Mail order (90-day supply): \$30/\$50/\$80.</p>	<p>You pay 20% of billed charges after deductible.</p>
Medicare allowable:	\$150										
Medicare pays 80%:	\$120										
Plan pays 80% of balance:	\$24										
You pay:	\$6										
<p>Medicare pays 80% of Medicare allowable; plan pays benefits at 80%. If that benefit is greater than Medicare, plan pays the difference. In most cases the plan pays nothing. You pay the 20% balance.</p> <p>Example:<sup>1</sup></p> <table border="0" data-bbox="138 1291 487 1407"> <tr><td>Medicare allowable:</td><td>\$150</td></tr> <tr><td>Medicare pays 80%:</td><td>\$120</td></tr> <tr><td>Plan pays:</td><td>\$0</td></tr> <tr><td>You pay:</td><td>\$30</td></tr> </table>	Medicare allowable:	\$150	Medicare pays 80%:	\$120	Plan pays:	\$0	You pay:	\$30	<p>You pay 20%; Medicare pays 80%</p>	<p>At participating pharmacies: Retail (30-day supply): \$15/\$25/\$40. Mail order (90-day supply): \$30/\$50/\$80.</p>	<p>You pay 20% of billed charges after deductible.</p>
Medicare allowable:	\$150										
Medicare pays 80%:	\$120										
Plan pays:	\$0										
You pay:	\$30										
<p>You pay nothing. Medicare pays 80% of allowable; plan pays balance.</p> <p>Example:<sup>1</sup></p> <table border="0" data-bbox="138 1480 487 1596"> <tr><td>Medicare allowable:</td><td>\$150</td></tr> <tr><td>Medicare pays 80%:</td><td>\$120</td></tr> <tr><td>Plan pays 100% of balance:</td><td>\$30</td></tr> <tr><td>You pay:</td><td>\$0</td></tr> </table>	Medicare allowable:	\$150	Medicare pays 80%:	\$120	Plan pays 100% of balance:	\$30	You pay:	\$0	<p>You pay nothing, Medicare and plan pay 100%</p>	<p>Retail (30-day supply): \$15/\$25/\$40. Mail order (90-day supply): \$30/\$50/\$80.</p>	<p>After deductible, most benefits will be reimbursed at 100%.</p>
Medicare allowable:	\$150										
Medicare pays 80%:	\$120										
Plan pays 100% of balance:	\$30										
You pay:	\$0										
<p>Medicare pays 80% of Medicare allowable; plan pays 80% of the balance; you pay any remaining balance.</p> <p>Example:<sup>1</sup></p> <table border="0" data-bbox="138 1669 487 1785"> <tr><td>Medicare allowable:</td><td>\$150</td></tr> <tr><td>Medicare pays 80%:</td><td>\$120</td></tr> <tr><td>Plan pays 80% of balance:</td><td>\$24</td></tr> <tr><td>You pay:</td><td>\$6</td></tr> </table>	Medicare allowable:	\$150	Medicare pays 80%:	\$120	Plan pays 80% of balance:	\$24	You pay:	\$6	<p>Medicare pays 80%, then plan pays 80% of the balance; you pay the amount remaining</p>	<p>Not covered</p>	<p>You pay 20% of billed charges after deductible.</p>
Medicare allowable:	\$150										
Medicare pays 80%:	\$120										
Plan pays 80% of balance:	\$24										
You pay:	\$6										

These examples assume that you have met your annual deductible, and that your doctor accepts your plan. Your plan will pay 100% of your covered expenses. Actual charges for office visits are usually based on your insurance assignment, you are also responsible for balance billing. Call the plan for details.

All family members have outpatient prescription drug coverage (as verified by CMS) through

## How Medicare Works with UC Medical Plans

Plan	Preventive Physical Exam	Durable Medical Equipment	Eye Exams	Hearing Exams/ Hearing Aids	Chiropractor	Acupuncture
<b>Health Net/ Medicare HMO Health Net Medicare COB Health Net Medicare Private Fee- for-Service</b>	No charge	No charge	\$15	Exam: \$15, 2 standard hearing aids (analog or digital) every 36 months at no charge	\$15/20 visits/ calendar year	Not covered
<b>Kaiser/Senior Advantage</b>	\$15	No charge	\$15	Exam: \$15, hearing aids every 36 months, \$2,500 maximum per ear (medically necessary)	\$15 (manual manipulation as covered by Medicare only)	Not covered
<b>Western Health Advantage/WHA Care+</b>	No charge	No charge	\$15	Exam: \$15, hearing aids every 36 months, \$15 copay (maximum \$2,000)	\$15 (as required by Medicare only)	Not covered
<b>Blue Cross PLUS In-Network</b>	No charge	No copay	\$20 (medically necessary)	Exam \$20, aids 50% (Max. \$2,000, and 2 aids/36 months analog or digital)	\$20 (Network Panel only). Must be a licensed ASHP provider.	\$20 (Network Panel only). Must be a licensed ASHP provider.
<b>Blue Cross PLUS Out-of- Network</b>	You pay 30%	You pay 30%	Routine exams not covered. Medicare pays 80% of approved services, plan does not pay in addition.	Exam 30%, aids 50% (Max. \$2,000 and 2 aids/36 months analog or digital)	Medicare pays 80% of approved services, plan does not pay in addition	Not covered
<b>Blue Cross PPO</b>	No copay (deductible waived)	You pay 20%	Medicare pays 80% of approved services, plan does not pay in addition.	Exam 20%, aids 20% (Max. \$2,000 and 2 aids/36 month analog or digital)	Medicare pays 80% of approved services, plan does not pay in addition	You pay 20%
<b>Core</b>	Medicare and plan cover 80%, you pay 20%	You pay 20%	You pay 20% (when medically necessary).	Not covered	You pay 20%	You pay 20% (\$500 maximum/calendar year)
<b>High Option Supplement to Medicare</b>	No copay (deductible applies)	No copay, if covered by Medicare; 20% if not covered by Medicare (deductible applies)	Not covered	Not covered	No copay, network providers only; when Medicare is exhausted, 20% copay after deductible	Network providers only. You pay 20% (deductible applies) \$500 maximum/calendar year limit
<b>PPO Medicare without Prescription Drugs</b>	No copay (deductible waived)	You pay 20%	Medicare pays 80% of approved services, plan does not pay in addition.	Exam 20%, aids 20% (Max. \$2,000 and 2 aids/36 month analog or digital)	Medicare pays 80% of approved services, plan does not pay in addition	You pay 20%

Coordination of these benefits with Medicare varies depending on the type of Medicare coordination and what is covered by Medicare. Inpatient services are covered by Medicare the same as hospitalization.

# Medical Plan Deductibles and Out-of-Pocket Maximums

Plan	Calendar Year Deductible	Annual Out-of-Pocket Maximum Medical Benefits	Lifetime Maximum
<b>Health Net/Medicare HMO Health Net Medicare COB Health Net Medicare Private Fee-for-Service</b>	\$0	3 inpatient copays per person per year	No overall maximum lifetime benefit. Some HMOs may have lifetime maximums for specific benefits; see plan booklets.
<b>Kaiser/Senior Advantage</b>	\$0	Individual: \$1,500 Family (3 members or more): \$3,000	No overall maximum lifetime benefit. Some HMOs may have lifetime maximums for specific benefits; see plan booklets.
<b>Western Health Advantage/ WHA Care+</b>	\$0	Individual: \$1,000 Family (2 members or more): \$3,000	No overall maximum lifetime benefit. Some HMOs may have lifetime maximums for specific benefits; see plan booklets.
<b>Blue Cross PLUS In-Network</b>	\$0	Individual: \$1,500 Family: \$4,500	Unlimited
<b>Blue Cross PLUS Out-of-Network</b>	Individual: \$500 Family: \$1,500	Individual: \$5,000 Family: \$15,000	\$2,000,000/member
<b>Blue Cross PPO</b>	\$100/member	\$1,500/member	\$5,000,000/member
<b>Core</b>	\$100/member	\$1,260/member	\$2,000,000/member
<b>High Option Supplement to Medicare</b>	\$50/member	\$1,050/member	\$2,000,000/member
<b>PPO Medicare without Prescription Drugs</b>	\$100/member	\$1,500/member	\$5,000,000/member

## Calendar Year Deductible

The calendar year deductible is the amount you must pay before the medical plan begins to pay a percentage of the total cost of benefits. Until the deductible is met, you pay the total cost not covered by Medicare. Review each plan's annual deductible and monthly premium to decide which plan is the best for you.

## Out-of-Pocket Maximum

The out-of-pocket maximum is the annual ceiling for your copayments or coinsurance during the calendar year. After this amount is reached, the plan may pay benefits at 100 percent after Medicare. Some expenses do not apply toward the maximum (see plan booklets).

## Lifetime Maximum

The most that a plan will pay for any person in his/her lifetime.

## Medicare Part D Prescription Drugs: Calendar Year Out-of-Pocket Maximums

(Benefits after reaching maximum vary by plan. See plan booklet for details.)

<b>Health Net/Seniority Plus:</b>	\$2,000 per member (excludes generic substitution costs). When member pays difference between Part D generic and brand drug (generic substitution costs), out-of-pocket maximum is \$4,050/member.
<b>Health Net Medicare COB:</b>	\$2,000 per member (excludes generic substitution costs). When member pays difference between Part D generic and brand drug (generic substitution costs), out-of-pocket maximum is \$4,050/member.
<b>Health Net Medicare Private Fee-For-Service:</b>	\$2,000 per member (excludes generic substitution costs). When member pays difference between Part D generic and brand drug (generic substitution costs), out-of-pocket maximum is \$4,050/member.
<b>Kaiser/Senior Advantage:</b>	\$4,050 per member
<b>Western Health Advantage/WHA Care+:</b>	\$4,050 per member
<b>Blue Cross PLUS In-Network:</b>	\$4,050 per member (applies to retail and mail order)
<b>Blue Cross PLUS Out-of-Network:</b>	\$4,050 per member (applies to retail and mail order)
<b>Blue Cross PPO:</b>	\$4,050 per member (applies to retail and mail order)
<b>Core:</b>	\$1,000 per member
<b>High Option Supplement to Medicare:</b>	\$1,000 per member
<b>PPO Medicare without Prescription Drugs:</b>	Prescription drugs are not a covered benefit in this plan.

By authority of the Regents, University of California Human Resources and Benefits, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. Source documents are available for inspection upon request (1-800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees, and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. Contact your Human Resources Office for more information.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision coverage because you terminate employment (for reasons other than gross misconduct); your work hours are reduced below the eligible status for these benefits; you die, divorce, or are legally separated; or a child ceases to be an eligible dependent. Note: The continuation period is calculated from the earliest of these qualifying events and runs concurrently with any other UC options for continued coverage. See your Benefits Representative for more information.

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Website address: [atyourservice.ucop.edu](http://atyourservice.ucop.edu)



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