

University of California



Medicare Factsheet

for LANL 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 three parts:

1. **Medicare Part A (hospital insurance)**, which 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 (or your spouse, former spouse or deceased spouse) paid Medicare taxes while working.
2. **Medicare Part B (medical insurance)**, which helps pay for doctors, outpatient hospital care and other medical services. Most people pay a monthly premium for Part B (\$88.50 per person in 2006).
3. **Medicare Part D (prescription drug insurance)**
UC medical plans coordinate with Medicare Part D; you do not need to enroll (see right).

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.

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.

The SSA will send you Medicare enrollment information about four months prior to your 65th birthday.

If you do not enroll in Part B when you are first eligible, Medicare has an annual General Enrollment Period (GEP) between January 1 and March 31, with coverage effective July 1 of that year. The SSA will add a surcharge to the Part B premium if you or your eligible family member(s) do not enroll in Part B when first eligible. So, it is important that you enroll when you first become eligible.

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

UC-Sponsored Medical Plans and Medicare Part D

Starting January 1, 2006, new prescription drug plan coverage will be available to everyone with Medicare. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. **If you are enrolled in UC-sponsored medical insurance for Medicare enrollees, you do not need to enroll in a non-UC Medicare Prescription Drug plan because your plan includes prescription drug coverage.**

The University of California has determined that the prescription drug coverages offered by the UC-sponsored plans is considered Creditable Coverage, which means that UC's plans on average are expected to pay out as much or more than the standard Medicare prescription drug coverage will pay.

Please be advised: if you decide to enroll in a Medicare prescription drug plan, you may not continue your UC-sponsored medical plan coverage and you must immediately notify the UC Customer Service Center at 1-800-888-8267.

If you drop or lose your UC-sponsored coverage and do not enroll in Medicare prescription drug coverage within 63 days after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. For additional details, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

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 since federal law stipulates that your UC group employer plan will be your primary coverage. At age 65, you will automatically be enrolled in Medicare Part A, and your UC-sponsored health plan will coordinate hospital benefits with Medicare. When you retire, you must immediately enroll in Medicare Part B.

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 when you turn 65.

Failure to comply with this regulation can result in permanently losing your UC-sponsored medical coverage.

Medicare generally does not cover health services outside the U.S. UC, therefore, 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. The packet will include a *Medicare Declaration* form (UBEN 126), which you must complete and return with a copy of your Medicare card or your Social Security denial letter.

If you are eligible for Medicare Parts A and B:

- 1) Complete Sections 1, 2, and 4 (and 3, for any eligible family members) of the *Medicare Declaration* form and return the signed copy to UC. Keep the pink copy for your records.
- 2) Attach a copy of the Medicare card. If you do not have a copy of the card, attach a copy of the award letter from Social Security which displays the Medicare effective dates for both parts of Medicare.
- 3) **If you are enrolled in a UC-sponsored Health Maintenance Organization (HMO)**, you must also complete and return to your medical plan carrier the *Medicare Advantage Universal Enrollment Form* and assign your Medicare benefits to your plan. You should receive the form in the UC packet of information and in a special Medicare mailing from your medical plan carrier. You need to complete and return only one.

If you have not received the form by your 65th birthday, please call your medical plan or the UC Customer Service Center at 1-800-888-8267.

Please note: UC will transfer your coverage to the Medicare plan for Medicare enrollees effective the first of the month after the appropriate forms are received or on the Medicare effective date, whichever is later.

If you or a family member are in Medicare and the other members of your family are not, those in Medicare are enrolled in the Medicare version of the plan while those not in Medicare remain in the basic version of the plan.

You will lose your UC-sponsored medical coverage if:

- You qualify for premium-free Medicare Part A and do not sign up for Medicare Part B or discontinue Part B coverage at any time;
- You enroll in Health Net/Seniority Plus, Kaiser Permanente/Senior Advantage, PacifiCare (CA or NV)/Secure Horizons, or WHA Care+ and you do not assign your Medicare benefits to the plan; or
- You assign your Medicare benefits to a non-UC-sponsored medical plan.
- You purchase a non-UC Medicare Part D Prescription Drug plan.

If you are not eligible for Medicare Part A:

- 1) Complete Sections 1, 2, 4 and 5 (and 3, for any eligible family members) of the *Medicare Declaration* form and return the signed copy to UC. Keep the pink copy for your records.
- 2) Attach a copy of the Social Security denial letter.

If you become eligible for premium-free Part A at a future date, either through your own work, your spouse, or a former or deceased spouse, contact the UC Customer Service Center as soon as possible. If you are not eligible for premium-free Part A, you will not be required to enroll in Part B, although it is recommended. Regardless of your decision, coverage will continue under the basic UC medical plan.

If You Return to Work at UC or LANL

If you or your family members are covered by Medicare and you become eligible for employee medical 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 cancel your retiree medical coverage and 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 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, 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, per diem, 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

All UC-sponsored medical carriers have a separate plan for Medicare enrollees. The Medicare version of your medical plan may have different benefits, service areas and doctors than the basic version of the plan.

Private Contracts and Non-Medicare Providers

To receive plan benefits, 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,” neither Medicare nor your UC-sponsored medical plan will cover those services.

UC-Sponsored HMOs

The Medicare versions of the UC-sponsored HMO plans are:

Health Net = Health Net/Seniority Plus
Kaiser = Kaiser/Senior Advantage
PacifiCare = PacifiCare/Secure Horizons
Western Health Advantage = WHA Care+

To enroll in one of these Medicare HMOs, you must live in that plan’s service area. The Medicare version of your HMO may have a different service area than the service area for the basic HMO. If the Medicare version of your HMO is not available where you live, you and your family may transfer to any UC plan available in your area.

Blue Cross PLUS, Blue Cross PPO, Core–NM, High Option, Select EPO, Options PPO

The Medicare versions of Blue Cross PLUS, Blue Cross PPO, Core–NM, Select EPO, High Option or Options PPO have the same service areas as the basic plans. You can change medical plans only during Open Enrollment.

How Medicare Works with UC LANL Medical Plans

Select EPO, Options PPO, and Core

When you receive services, Medicare is the primary payer, and your plan is secondary. You may see any Medicare provider (a doctor who has a contract with Medicare). If your Medicare provider “accepts assignment,” that means he/she will accept the Medicare-approved rate for services. This is the rate that Medicare and the plan use to figure their payments.

If the amount the plans would normally pay is *less than* what Medicare pays, the plans pay nothing. If the amount the plans would normally pay is *greater than* what Medicare pays, the plans pay the difference (up to the Medicare allowable) between their normal payment and Medicare’s payment.

If your doctor does not accept Medicare assignment, he/she can bill you for an additional amount over the Medicare allowable rate. This is called “balance billing.” In these cases, the plans calculate their benefit on the Medicare “limiting charge” (generally 15 percent more than the Medicare allowable rate) or the plan’s allowable rate, whichever is less, and then subtract Medicare’s payment. The plans pay the difference and you pay any balance.

Here is an example of how the plans would pay if your doctor does not accept Medicare assignment:

Total charge:	\$140.00
Medicare allowable:	100.00
Limiting charge:	115.00
Medicare pays:	80.00
Plan’s normal payment:	103.50
Plan pays:	23.50
You pay:	\$ 11.50

Since you are responsible for all charges up to Medicare’s limiting charge, your costs are minimized by using doctors who accept Medicare assignment.

Each plan has an annual deductible that you must pay. Once you meet the deductible, the plan coordinates payment with Medicare to cover a percentage of your expenses. The plans also have an annual out-of-pocket maximum. Once you have paid this amount for services each year, the plan will cover your eligible expenses at 100 percent.

Plan	Doctor Visit	Hospitalization	Emergency Room	Lab Work	Prescription Drug Copay Generic/ Preferred Brand/ Non-preferred Brand	Medical Services when Traveling outside U.S. ⁵
Select EPO^{1,2} Options PPO^{1,2}	Select EPO: You pay \$20 copay; Medicare and plan pay balance. Options PPO: Medicare allowable: \$150 Medicare pays 80%: Plan's normal payment: \$135 Plan pays: \$15 You pay: \$15	Medicare allowable: \$10,000 Medicare pays: \$9,048 Plan's normal payment: \$9,000 Plan pays: \$0 You pay: \$952	Medicare pays 80% of allowable. You pay \$75 copayment (waived if admitted) plus 10%.	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (up to a 31-day supply): \$15/\$30/\$45 ^{3,4} Mail order (32 to 90-day supply): \$30/\$60/\$90	Select EPO: Emergency services only. You pay \$75 plus 10%. Options PPO NM or National: After \$500 deductible, plan pays 60%; you pay 40%. Options PPO Out-of-Area: After \$250 deductible, plan pays 90%; you pay 10%.
Core-NM^{1,2}	Medicare allowable: \$150 Medicare pays 80%: Plan pays: \$0 You pay: \$30	You pay 20%, plan pays 80% of the Medicare Hospitalization Deductible (\$952 in 2006). After that, Medicare pays 100% for the first 60 days and a fixed amount for days 61–150. Then you pay 20%; plan pays 80%.	You pay 20%; Medicare pays 80%	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (up to a 30-day supply): \$15/\$30/\$45 ^{3,4} Mail order (90-day supply): \$30/\$60/\$90; \$1,000 out-of-pocket maximum	After \$200 deductible, you pay 20%; plan pays 80%

- 1 The examples assume that you have met your annual deductible, and that your doctor accepts Medicare assignment.
- 2 Actual charges for office visits are usually higher than the Medicare allowable. If doctor does not accept assignment, you are also responsible for balance billing (see page 4).
- 3 If member or doctor requests brand name drug when generic equivalent is available, member pays generic copayment plus cost difference between brand and generic. Member pays cost difference when selecting brand name over available generic.
- 4 Member is responsible for paying the difference between plan's contracted rate and the amount billed by a non-participating pharmacy.
- 5 Does not apply if your permanent address is outside the U.S.

How Medicare Works with UC LANL Medical Plans

PLAN	OTHER BENEFITS			Durable Medical Equipment	Eye Exams
	Hospice (Inpatient)	Home Health Care	Skilled Nursing Facility		
Select EPO	10%; no deductible (maximum \$7,400 per lifetime). Notification by physician required.	10%; notification by physician required	10% (100 day maximum per calendar year); no deductible. Notification by physician required.	10% ¹	Medically necessary: \$20. Routine exams not covered.
Options PPO New Mexico	10%; no deductible (maximum \$7,400 per lifetime) ¹	10% network	10% (100 days per calendar year); no deductible. ¹	10% ¹	Medically necessary: \$20. Routine exams not covered.
National	10%; no deductible (maximum \$7,400 per lifetime) ¹	10% network	10% (100 days per calendar year); no deductible. ¹	10% ¹	Medically necessary: \$20. Routine exams not covered.
Out-of-Area	10%; no deductible (maximum \$7,400 per lifetime) ¹	10% (up to 100 visits per calendar year) ¹	10% (70 days per calendar year); no deductible ¹	10% ¹	Medically necessary: 10%. Routine exams not covered.
Core–New Mexico	20% (Lifetime Maximums: Inpatient 30 days/Outpatient \$5,000)	20% (up to 100 visits per calendar year)	20% (up to 120 days per calendar year)	20%	20% (medically necessary)

1 Member must provide UHC with notification for these services or a \$300 penalty per instance will apply.

2 For treatment of disease, illness, or injury.

3 UHC plans: All services must be approved in advance by PacifiCare Behavioral Health, Inc.; 1-800-817-8811. The calendar year deductible, benefits, level, and lifetime maximums are combined for a member who transfers between the UHC plans.

4 A separate \$3,000 individual/\$9,000 family out-of-pocket maximum applies to all mental health PPO benefits.

5 For UHC plans, limited to one treatment episode per person, per calendar year, for inpatient and outpatient treatment (up to \$10,000).

6 Lifetime maximum per person for all inpatient services: 130 days.

		BEHAVIORAL HEALTH³			
Chiropractor	Acupuncture	Mental Health Inpatient	Mental Health Outpatient	Substance Abuse Inpatient⁵	Substance Abuse Outpatient⁵
\$20 (20 visits per calendar year)	\$20 (20 visits per calendar year)	No copayment	\$15 per visit copayment	Detox: 20% of auth. charges; no deductible. Rehab: 20% of auth. charges (50% for non-compliance); \$250 calendar year deductible ⁶	Rehab: 20% of authorized charges; no deductible
\$20 (20 visits per calendar year, combined in- and out-of-network)	\$20 (20 visits per calendar year, combined in- and out-of-network)	No copayment	\$15 per visit copayment	Detox: 20% of auth. charges; no deductible. Rehab: 20% of auth. charges (50% for non-compliance); \$250 calendar year deductible ⁶	Rehab: 20% coinsurance. Calendar year benefit maximum per person: \$3,500
\$20 (20 visits per calendar year, combined in- and out-of-network)	\$20 (20 visits per calendar year, combined in- and out-of-network)	10% \$250 calendar year deductible for all inpatient and outpatient services. ⁴	10% \$250 calendar year deductible for all inpatient and outpatient services. ⁴	Detox: 20% coinsurance. Rehab: 20% coinsurance (50% for non-compliance) ⁶	Rehab: 20% coinsurance. Calendar year benefit maximum per person: \$3,500
10% (20 visits per calendar year)	10% (20 visits per calendar year)	10% \$250 calendar year deductible for all inpatient and outpatient services. ⁴	10% \$250 calendar year deductible for all inpatient and outpatient services. ⁴	Detox: 20% coinsurance. Rehab: 20% coinsurance (50% for non-compliance) ⁶	Rehab: 20% coinsurance. Calendar year benefit maximum per person: \$3,500
20%	20% (\$500 maximum/calendar year) ²	Not covered	Not covered	Not covered	Not covered

Medical Plan Deductibles and Out-of-Pocket Maximums

	Calendar Year Deductible	Annual Out-of-Pocket Maximum	Lifetime Maximum
Select EPO	Individual: \$150 ¹ Family: \$450 ¹	Individual: \$2,000 Family: \$6,000	None
Options PPO New Mexico National	Individual: \$250 ¹ Family: \$750 ¹	Individual: \$3,000 ² Family: \$9,000 ²	None
Out-of-Area	Individual: \$250 ¹ Family: \$750 ¹	Individual: \$3,000 Family: \$9,000	\$2,000,000
Core–New Mexico³	\$200 per member	\$1,260 per member (medical); \$1,000 per member (prescription drugs)	\$2,000,000

- 1 Visit copayments, emergency room and inpatient hospital copayments are not subject to and do not apply to the calendar year deductible.
- 2 Under the Medical portion of the PPO plan, the PPO In-Net-work calendar year deductible, visit copayments, the emergency room copayment and coinsurance do apply to the Annual Out-of-Pocket Limit amount.
- 3 When living outside the U.S., the non-Medicare plan benefits apply. Refer to plan booklet for details.

Calendar Year Deductible

The calendar year deductible is the amount you must pay for medical services 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 best for you.

Annual 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 will pay benefits at 100 percent after Medicare. Some expenses do not apply toward the maximum (see plan booklets).

Lifetime Maximum

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

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



University of California
Human Resources and Benefits
P.O. Box 24570
Oakland, CA 94623-1570

