

University of California



Medicare Factsheet

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.

About Medicare

Medicare has two 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 (\$66.60 per person in 2004).

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.

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.

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 from your local Social Security Administration office.

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.

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).

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 the *Medicare+Choice Enrollment Form* and assign your Medicare benefits to your plan. You should receive the form in a special Medicare mailing from your medical plan carrier.

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 at any time discontinue Part B coverage;
- 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.

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. Coverage will continue under the basic UC medical plan.

If You Return to Work at the University

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 as an employee 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 enrolling as an employee, and your retiree medical coverage will be canceled. 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 employment excludes you from UCRP membership (e.g., you are appointed by agreement, per diem, or your appointment is for less than 43.75 percent time), you are not eligible for employee medical benefits. 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

To receive plan benefits, you must use a provider who accepts Medicare. If your doctor does not take Medicare patients and 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 (CA or NM), High Option, Select EPO, Options PPO

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

How Medicare Works with UC California Medical Plans

HMOs

When you join a UC-sponsored HMO medical plan, you assign your Medicare benefit to the HMO. Medicare pays a flat fee to the plan each month, and the HMO agrees to assume full responsibility for your care. UC HMO plans also provide additional benefits that are not covered by Medicare (for example, prescriptions).

Blue Cross PLUS, Blue Cross PPO, High Option, and Core

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 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 “out-of-network” benefit level.

In **Blue Cross PPO, Core, and High Option Supplement**, you may see any Medicare provider. If your Medicare provider “accepts assignment” that means he/she will accept the Medicare-approved rate for services. However, if your doctor does not accept Medicare assignment, he/she can bill you for an additional amount (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 plan’s *Evidence of Coverage* booklet.

Plan	Doctor Visit								
Health Net/Seniority Plus PacifiCare/Secure Horizons Western Health Advantage/ WHA Care+ Kaiser/Senior Advantage	You pay \$10 copay; Medicare and plan pay the balance								
Blue Cross PLUS In-network¹	You pay \$20 copay; Medicare and plan pay the balance								
Out-of-network¹	<table> <tr> <td>Medicare allowable:²</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: ²	\$150	Medicare pays 80%:	\$120	Plan pays:	\$0	You pay:	\$30
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Plan pays 100% of balance:	\$30								
You pay:	\$0								

1 The examples assume that you have met your annual deductible, and that your plan will pay for services after you meet your annual out-of-pocket maximum. Remember, after you meet your annual out-of-pocket maximum, your plan will pay for services.

2 Actual charges for office visits are usually higher than the Medicare allowable. If

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

Hospitalization	Emergency Room	Lab Work	Prescription Drug Copay Generic/Brand/Nonformulary	Medical Services when Traveling out of U.S.³
You pay \$250 copay per admittance. Medicare and plan pay the balance.	You pay \$50 copay (waived if admitted); Medicare and plan pay the balance	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (30-day supply): you pay \$10/\$20/\$35; plan pays balance. Mail order (90-day supply): you pay \$20/\$40/\$70; plan pays balance.	Emergencies/urgent care covered at 100%. (PCP/HMO must be notified, you pay ER copay.) For other non-emergency, urgent services you pay full costs, plan and Medicare do not pay.
You pay \$250 copay per admittance. Medicare and plan pay the balance.	You pay \$75 copay (waived if admitted); Medicare and plan pay the balance	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (30-day supply): you pay \$15/\$25/\$40; plan pays balance. Mail order (90-day supply): you pay \$30/\$50/\$80; plan pays balance.	Emergencies/urgent care covered at 100%. (PCP must be notified, you pay ER copay.) Other services covered as out-of-network (see below).
You pay 30%, plan pays 70% of the Medicare Hospitalization Deductible (\$876 in 2004). After that, Medicare pays 100% for the first 60 days and a fixed amount for days 61–150. Then you pay 30%; plan pays 70%.	You pay \$75 copay (waived if admitted); Medicare and plan pay the balance	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (30-day supply): you pay \$15/\$25/\$40; plan pays balance. Mail order (90-day supply): you pay \$30/\$50/\$80; plan pays balance.	After \$500 deductible, you pay 30%, plan pays 70%
You pay 20%, plan pays 80% of the Medicare Hospitalization Deductible (\$876 in 2004). 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%.	Medicare pays 80%, then plan pays 80% of the balance; you pay the balance	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (30-day supply): you pay \$15/\$25/\$40; plan pays balance. Mail order (90-day supply): you pay \$30/\$50/\$80; plan pays balance.	After \$100 deductible, you pay 20%, plan pays 80% for PPO providers; you pay 40%, plan pays 60% for non-PPO providers
You pay 20%, plan pays 80% of the Medicare Hospitalization Deductible (\$876 in 2004). 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%	You pay 20% of retail cost, plan pays 80%. After you reach out-of-pocket maximum, plan pays 100%.	After \$150 deductible, you pay 20%, plan pays 80%
You pay nothing. Plan and Medicare pay 100% for the first 60 days.	You pay nothing, Medicare and plan pay 100%	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (30-day supply): you pay \$15/\$25/\$40; plan pays balance. Mail order (90-day supply): you pay \$30/\$50/\$80; plan pays balance. Annual prescription out-of-pocket max: \$1,000/person	After \$50 deductible, you pay 20%, plan pays 80%

doctor accepts Medicare assignment.
pay 100% of your expenses.

doctor does not accept assignment, you are also responsible for balance billing.

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 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 Select EPO and Options PPO plans calculate their benefit on the Medicare-allowable rate plus 15 percent and then subtract Medicare’s payment. The plans pay the difference and you pay any balance. 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
Doctor Accepts Medicare Assignment Select EPO¹ Options PPO¹	Select EPO: You pay \$20 copay; Medicare and plan pay balance. Options PPO: Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays: \$15 You pay: \$15
Doctor Does Not Accept Medicare Assignment Select EPO Options PPO	Select EPO: You pay \$20 copay; Medicare and plan pay balance. Options PPO: Total charge: \$172 Medicare allowable: ² \$150 Medicare pays 80%: \$120 Plan pays: \$35 You pay: \$17
Core¹	Medicare allowable: ² \$150 Medicare pays 80%: \$120 Plan pays: \$0 You pay: \$30

1 The examples assume that you have met your annual deductible, and that your

2 Actual charges for office visits are usually higher than the Medicare allowable. If

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

Hospitalization	Emergency Room	Lab Work	Prescription Drug Copay Generic/Brand/Nonformulary	Medical Services when Traveling out of U.S. ³
Medicare allowable: \$10,000 Medicare pays: \$9,160 Plan pays: \$0 You pay: \$840	Medicare pays 80% of allowable. You pay \$75 copay (waived if admitted) plus 10%.	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (31-day supply): \$15/\$30/\$45 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%.
Total charge: \$11,500 Medicare allowable: \$10,000 Medicare pays: \$9,160 Plan pays: \$1,190 You pay: \$1,150	Medicare pays 80% of allowable. You pay \$75 copay (waived if admitted) and you and the plan pay balance.	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (31-day supply): \$15/\$30/\$45 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%.
You pay 20%, plan pays 80% of the Medicare Hospitalization Deductible (\$876 in 2004). 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%	You pay 20% of retail cost, plan pays 80%. After you reach out-of-pocket maximum, plan pays 100%.	After \$150 deductible, you pay 20%, plan pays 80%

doctor accepts Medicare assignment.

doctor does not accept assignment, you are also responsible for balance billing.

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, annuitants, 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 Mattie Williams, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Executive Director Sheila O'Rourke, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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