MEDICARE AND YOUR STATE BENEFITS

Medicare Parts A & B

Active employees and their covered dependents do not have to sign up for Medicare Parts A & B when they become eligible because of age or disability as long as they continue to be active employees. Their State benefits coverage must continue as primary coverage, as long as they are active employees. **However, retirees and dependents of retirees must enroll in both Medicare Parts A & B as soon as they are eligible (due to age or disability) to have full claims coverage.** If you are a retiree or a covered dependent of a retiree and you are eligible for Medicare, Parts A & B become your primary insurance and the State health plan becomes a supplemental policy to Medicare. Medicare Part A helps pay for hospital care, some skilled nursing facility care, and hospice care; Medicare Part B helps pay for physician charges and other medical services.

If you are an employee, retiree, or a covered dependent that has Medicare entitlement because of End Stage Renal Disease (ESRD), see the ESRD rules that follow.

Retirees and/or their dependents enrolled in the State Health Benefits Program must enroll in both Parts A & B to have full coverage as soon as they are eligible, either due to age or disability. The State plan will cover only the portion of hospital and medical bills not covered by Medicare. **If you and/or your covered dependents are eligible for, but not enrolled in both Parts A & B, you will become responsible for the claims costs that Medicare would have paid.**

Age: Even If You Are Not Collecting

For most individuals who are not disabled, Medicare eligibility begins on the first day of the month in which they reach age 65. However, if you were born on the first day of a month, your Medicare eligibility begins on the first day of the month prior to the month in which you reach age 65. In order to have full coverage, retirees and their covered dependents must enroll in Parts A & B at age 65, regardless of what the Social Security Administration determines to be your full retirement age.

Even if you do not wish to start receiving your Social Security retirement benefit, you must still enroll in Medicare Parts A & B. You will be billed directly by the Social Security Administration for your Part B premium. For information on how to enroll in Medicare, call the Social Security Administration at 1-800-772-1213.

Disability

Persons who are certified as being disabled by the Social Security Administration become eligible for Medicare two years (24 months) after their disability determination date. Retirees and their covered dependents enrolled in the State's benefits program **MUST** enroll in Medicare Parts A & B if eligible due to disability, regardless of their age, in order to receive the maximum coverage available. If Social Security denies Medicare coverage, you must provide a copy of the Social Security's denial to the Employee Benefits Division. If your Medicare entitlement is due to disability and the Social Security Administration determines that your disability status ends, please provide the Employee Benefits Division documentation from the Social Security Administration stating when Medicare entitlement ended. It is your responsibility to notify the Employee Benefits Division of Medicare entitlement due to disability.

If the retiree and covered dependents fail to enroll in Medicare Parts A & B, the member will be responsible for the Medicare portion (about 80%) of all eligible services. The State will only pay as Medicare Supplemental Coverage (about 20%) towards eligible services.

End Stage Renal Disease (ESRD)

The information in this section only pertains to individuals who, according to the Centers for Medicare and Medicaid Services, are eligible for Medicare based on ESRD, not based on age or disability.

Individuals who have ESRD may be eligible for coverage under Medicare Parts A and B. It is strongly recommended that all employees, retirees, and their covered dependents who have ESRD read the Centers for Medicare and Medicaid Services publication, *Medicare Coverage for Kidney Dialysis and Kidney Transplant Services* before making any decisions about whether or not to enroll in Medicare Part A and/or Part B. To obtain a copy of this publication, visit a local Social Security office, call toll-free to 1-800-772-1213, or visit the website **www.socialsecurity.gov** and select *Other Medicare Information* (under the heading, *Medicare*), then select *More Medicare Publications* and finally, select *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*.

The information below regarding the Coordination of Benefits (COB) for Medicare due to End Stage Renal Disease (ESRD) pertains to individuals enrolled in an active employee group only.

During the 30-Month COB Period

When Medicare entitlement due to ESRD begins, there is a 30-month COB period (determined by Social Security) during which active employee group coverage remains the primary insurer, regardless of whether or not the individual is enrolled in Medicare Part A and/or Part B. Employees should never change their coverage level in the State health plan to a Medicare coverage level during their 30-month COB period.

After the 30-Month COB Period

NOTE: Individuals enrolled in a medical plan under the State's program and whose coverage is in an active employee group are not required to enroll in Medicare. However, if the individual chooses to enroll in Medicare Part A only, or both Parts A and B due to an ESRD entitlement (determined by Social Security), their claims will be processed according to the COB regulations provided below.

After a successful kidney transplant

Three years after a successful kidney transplant, Medicare is no longer the primary insurer. If Medicare eligibility ends, the employee should contact the SSA to confirm that both Part A and Part B have been cancelled. When the employee receives a cancellation letter from the SSA, if the employee is enrolled in a State medical plan with a Medicare coverage level, an active employee enrollment form should be submitted to change to a non-Medicare coverage level.

The following link is for the Social Security publication titled "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services":

www.medicare.gov/Publications/Pubs/pdf/10128.pdf

Active employees and their dependents covered by a State medical plan who are eligible for Medicare due to ESRD will have their claims processed as follows.

Active employees/dependents enrolled in both Medicare Part A & B:

- The State plan will remain the primary insurer for a 30-month coordination of benefits period determined by SSA; your coverage level in the State plan should not be changed to reflect Medicare enrollment until Medicare becomes the primary insurer.
- At the end of the 30-month coordination period, Medicare will become the primary insurer and the State plan will be the secondary insurer. At that time, you should complete an Active Employee Health Benefits enrollment form to change your State plan coverage level accordingly.

Active employees/dependents enrolled in Medicare Part A, but not Part B:

- The State plan will remain the primary insurer for the 30-month coordination of benefits period; your coverage level in the State plan should not be changed to reflect Medicare enrollment.
- At the end of the 30-month coordination period, Medicare Part A will become the primary insurer for Part A (hospital) claims. In order for the State plan to remain the primary insurer for Part B (medical) claims, your coverage level in the State plan should not be changed to reflect Medicare enrollment.

Active employees/dependents not enrolled in Medicare Part A or Part B:

- There will be no coordination of benefits and no change in the way the State plan processes claims.

If you/your dependent are no longer eligible for Medicare due to ESRD, you should contact the Social Security Administration to request a cancellation of both Medicare Parts A & B, as applicable. When you receive your cancellation letter from the SSA, if your coverage level in the State plan reflects Medicare enrollment, you should submit a copy of the SSA letter along with an Active Employee Health Benefits enrollment form requesting a coverage level reflecting "no Medicare" to your Agency Benefits Coordinator in your Human Resources office.

Retirees and their dependents covered by a State medical plan who are eligible for Medicare due to ESRD (and not for any other reason) will have claims their processed as follows.

Retirees/dependents enrolled in both Medicare Part A & B:

- The State plan will remain the primary insurer for a 30-month coordination of benefits period determined by SSA; your coverage level in the State plan should not be changed to reflect Medicare enrollment until Medicare becomes the primary insurer.
- At the end of the 30-month coordination period, Medicare will become the primary insurer and the State plan will be the secondary insurer. This is a qualifying event and you should complete a Retiree Health Benefits enrollment form to change your State plan coverage level accordingly (i.e., from "Individual & Spouse" to "Individual & One, One with Medicare").

Retirees/dependents enrolled in Medicare Part A, but not Part B:

- The State plan will remain the primary insurer for the 30-month coordination of benefits period; your coverage level in the State plan should not be changed to reflect Medicare enrollment.
- At the end of the 30-month coordination period, your coverage level should be changed to reflect Medicare eligibility. At that time, Medicare Part A will become the primary insurer for Part A (hospital) claims. The State plan will cover only the portion of Part B claims that Medicare would not have covered if the retiree/dependent was enrolled in Part B; the retiree/dependent will become responsible for the claims costs that Medicare Part B would have covered.

Retirees/dependents not enrolled in Medicare Part A or Part B:

- The State plan will remain the primary insurer for the 30-month coordination of benefits period; your coverage level in the State plan should not be changed to reflect Medicare enrollment.
- At the end of the 30-month coordination period, Medicare will become the primary insurer. At that time, you should complete a Retiree Health Benefits enrollment form to change your State plan coverage level accordingly (i.e., from "Individual & Spouse" to "Individual & One, One with Medicare"). The State plan will cover only the portion of claims that Medicare would not have covered if the retiree/dependent was enrolled in Parts A & B; the retiree/dependent will become responsible for the claims costs that Medicare would have covered.

If you/your dependent are no longer eligible for Medicare, you should contact the Social Security Administration to request a cancellation of both Medicare Parts A & B, as applicable. When you receive your cancellation letter from the SSA, if your coverage level in the State plan reflects Medicare enrollment, you should submit a copy of the SSA letter along with a Retiree Health and Welfare Benefits enrollment form requesting the appropriate coverage level to the Employee Benefits Division at the address on the inside front cover of this guide.

Medicare Coordination of Benefits (COB)

If you have questions about your coverage level in the State Retiree Health and Welfare Benefits Program, contact the Employee Benefits Division. If you have questions about claims payments and how your plan coordinates with Medicare, contact your Medical Plan.

Medicare Part D – Medicare Drug Benefit

How Does This Apply to You?

If you have prescription drug coverage through the State Employee and Retiree Health and Welfare Benefits Program, you are not required to enroll in Medicare Part D. For most people, keeping the State coverage and not enrolling in a Medicare Part D plan will be the most cost-effective prescription drug coverage. However, you should consider the premium, copay, coinsurance, deductible, and coverage gap costs under the plans you are considering to make the best decision for your personal coverage. For the 2012-2013 plan year, the State of Maryland Prescription

Drug Plan continues to be as good as, or better than, the standard Medicare Part D plan. See the Notice of Creditable Coverage in this guide.

If you have State prescription drug coverage, the Notice of Creditable coverage means that if you decide to keep the State prescription drug coverage and not enroll in Medicare Part D, you will be permitted to enroll in Medicare Part D at a later time without paying a higher premium, as long as you do not have a break in coverage of 63 or more days.

Retirees and Their Covered Dependents

As a retiree or a dependent of a retiree, if you decide to buy the Medicare Part D coverage and keep your State prescription coverage, Medicare Part D will become your primary source of prescription drug coverage, and the State coverage will be secondary. In other words, Medicare will pay benefits first, and then the State coverage will coordinate with the benefits that Medicare pays. Remember, you will have to pay both monthly premiums.

Here's How the State Plan Will Work as Your Secondary Coverage When You Have Primary Coverage Through Medicare Part D

- You will give the pharmacist your Medicare Part D card first as your primary insurance and your State prescription card as your secondary insurance.
- You must meet an annual Medicare Part D deductible before Medicare will begin to pay benefits. During this time, your State coverage will pay benefits and you will only be required to pay the applicable copays for State coverage. Once your copays combined with the State payments reach the annual Medicare deductible, Medicare will begin paying benefits. Your true out-of-pocket (TROOP) cost for the Part D plan will only reflect what you paid, and not what the State paid.
- After you have met any Medicare annual deductible, Medicare Part D will pay their portion of eligible costs of the drugs on their preferred drug list, up to the determined coverage gap. The State will pay benefits and will make up the difference between what Medicare pays, if anything, and the applicable State copay you are required to pay.
- When the amount of State copays you have paid during the fiscal year reaches $1,500 individual/$2,000 family you will have met the out-of-pocket maximum for the State prescription drug coverage. This means the State plan pays for eligible expenses not covered by your Medicare Part D plan in full for the rest of the plan year. You should still give your pharmacist your Medicare Part D card.

Active Employees and Covered Dependents

If you have prescription drug coverage because you are still working, or because your spouse or family member is still working, the employer coverage will remain your primary prescription drug coverage unless you drop it. If that coverage is creditable coverage, you can wait to enroll in Medicare Part D until a later time, and you will not pay more for your Part D premium when you enroll, as long as you do not have a break in coverage of 63 or more days.

Initial, Special, and General Enrollment Periods for Medicare Parts A & B

When you reach age 65, if your health benefits coverage is under a retiree's policy and you do not enroll in both Medicare Parts A & B, you will not have full claims coverage and your Part B premium may be penalized when you enroll later.

If your health benefits coverage is under an active employee's policy when you reach age 65, you do not have to enroll in Medicare until you retire, unless your employment or coverage under an Active employee's policy will end during your initial enrollment period. See the Special Enrollment Period information table on the left.

Initial Enrollment Period is the seven-month period for Medicare due to reaching age 65, as follows:

- If you reach age 65 on the 1st day of the month – Medicare eligibility begins the 1st day of the previous month; *Example: If your birthday is January 1st, you are eligible for Medicare on December 1st.*
- If you reach age 65 on the 2nd day through the last day of the month – Medicare eligibility begins the 1st day of the month you turn 65; *Example: If your birthday is January 2nd – 31st, you are eligible for Medicare on January 1st.*

Your Initial Enrollment Period begins three months prior to the month you are eligible for Medicare and ends three months after the month you are eligible for Medicare. The chart on the left shows the schedule for an Initial Enrollment Period and a sample schedule for a birth date of April 2nd – 30th.

Special Enrollment Period is an eight-month period beginning the month your group coverage ends or the month employment ends, whichever comes first. If you were eligible for Medicare, but didn't enroll because you had health benefits under an active employee's policy, you can enroll during your Special Enrollment Period without penalty to your Part B premium. **Special enrollment period rules don't apply if employment or active employee group coverage ends during your initial enrollment period.**

General Enrollment Period is a three month "Open Enrollment" period for Medicare each year from January 1st through March 31st for Part B coverage to start on July 1st of the same year. If you were eligible but not enrolled in Medicare and you did not have health benefits coverage under an active employee's policy, your Part B premium will be penalized 10% for every 12 months you were entitled to Part B but not enrolled.

If your Initial Enrollment Period or Special Enrollment Period enrollment falls between January 1st and March 31st, it is extremely important that you make it clear to the Social Security Administration representative you have an initial or special enrollment period. Otherwise, you may be enrolled as a general enrollment and your Part B coverage will not start until July 1st and your Part B premium may be penalized.

Medicare Due to Disability

The same rules apply if you are entitled to Medicare due to a disability. If you have health benefits coverage under an active employee's policy, you do not have to enroll in Medicare. **However, when your employment or active employee coverage ends, you must apply for Medicare Parts A & B in order to have full claims coverage. Otherwise, you will be responsible for the portion of claims that Medicare would have paid, had you been enrolled.**