**Medicare Coordination**

**Retired Participants Eligible For Medicare**

When you or your spouse (or same-sex domestic partner) reach age 65, whether or not you have retired and applied for Social Security benefits, you must be certain to enroll at your Social Security office for Medicare Part A and Part B benefits. This is vitally important to you because:

* Your benefits with this Plan will not duplicate any benefits you are legally entitled to receive.
* If you should forfeit any Medicare payment by your failure to enroll in time or by using a physician or other health care practitioner who contracts with you to treat you outside of the Medicare system, the amount you would have received from Medicare will be deducted from our payment(s) for any services covered by Medicare law.
* Medicare Part A and Part B benefits must be applied (whether elective or not) before Motion Picture Industry Health Plan benefits will be paid. You may enroll for Medicare any time during the three months preceding your 65th birthday and should do so at your earliest opportunity. Medicare hospital insurance (Part A) is free to you, but Medicare medical insurance (Part B) will require a premium. Medicare Part A provides inpatient hospital benefits, and Medicare Part B pays for necessary doctor’s services, outpatient hospital services, and other medical services and supplies not covered by Part A.

**Social Security Administration Toll – Free Number – (800) 772–1213**

**Enrollment**

You will need to contact your local Social Security office within 90 days before your 65th birthday. If you are age 65 or older and have applied for and established your monthly Social Security benefit, you ordinarily do not have to file an additional application for Medicare coverage. Medicare will mail you a card indicating that you have coverage under Parts A and B. You pay Medicare a monthly premium for Part B coverage. Your premiums for Part B coverage are ordinarily deducted from your Social Security benefits, if you receive them. It’s important that you enroll in both Medicare Parts A and B because at age 65, if you are retired, Medicare will become your primary medical coverage, in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the MPI Health Plan, the Plan will pay the difference, only up to the maximum current benefit allowable. In addition, if Medicare denies payment for a service that the Plan considers eligible, the Plan will pay up to its normal benefit amount. Services not covered by Medicare may include prescription drugs. No benefits will be payable under the Plan for eligible Medicare benefits that are not paid because you did not enroll, qualify, or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

**Dependent Spouse Age 65**

If your dependent spouse (or same-sex domestic partner) reaches age 65 prior to your 65th birthday and is not entitled to Social Security benefits as a result of his/her own employment, such spouse may be required to pay a monthly premium for Medicare hospital insurance (Part A). Be sure that prior to your spouse’s 65th birthday you check with your Social Security office for a determination regarding the requirement for such premium payments.

**Aliens Age 65**

All aliens who have reached age 65 must also check with their Social Security office to determine the requirements for Medicare hospital insurance (Part A). Spouses (or same-sex domestic partners) and aliens who are required to pay the premium for Medicare hospital insurance must do so to be protected under Plan guidelines. The Plan will not duplicate any benefits which your spouse (or same-sex domestic partner) or you are legally entitled to receive under Medicare by payment of the Medicare premium.

**Medicare for the Disabled**

Medicare protection is also available for disabled people under age 65. These include workers at any age, person who become disabled before age 22, disabled widow and disabled dependent widowers (50 or over) who have been entitled to Social Security or Railroad Retirement Disability checks for two years or more. Also, people under 65 who need long-term dialysis treatment for chronic kidney disease or require a kidney transplant can be covered by Medicare.

**Medicare and MPIHP**

When you are eligible for Medicare, your benefits with the Motion Picture Industry Health Plan will remain as before; they will not duplicate any payment you may receive from Medicare but will be used to pay reasonable expenses (subject to the limitations contained in this Summary Plan Description) not paid by Medicare up to the full amount of such expenses and will apply to some services not covered by Medicare such as care outside the United States.

**When you are eligible for Medicare, hospital claims should be handled as follows:**

* Present your Medicare card and your Hospital Benefit Card to obtain admission to the hospital.
* The hospital will bill Medicare and Blue Shield directly.
* If you receive a bill from the hospital, for which Medicare has denied payment, you may submit it to Blue Shield for reimbursement of covered charges that are not payable by Medicare. A copy of the Explanation of Medicare Benefits statement (EOMB) must be submitted with the bill indicating Medicare’s reason for denial.
* If you have paid the hospital, payment will be made to you. Otherwise, payment will be made directly to the hospital. All medical bills (doctor, laboratory, x-ray, ambulance, etc.) must be presented to Medicare first (either by the provider or you). After Medicare has processed the claim, you will receive an Explanation of Medicare Benefits statement (EOMB) showing the amount charged by the provider and showing the amount Medicare paid, if any. Attach a copy of the EOMB to the corresponding itemized bill and send them together with a Motion Picture Industry Health Plan Comprehensive Medical Claim form (Part 1 completed in full by you) to the Plan Office. Bills and EOMB statements received separately will be returned. It is in your best interest to make a copy of the EOMB for your records, as we cannot return the Medicare’s Explanation of Medical Benefits statement to you. “Itemized” means all claims submitted must contain these seven essential items:
  1. Diagnosis: this is the doctor’s medical description of the illness or injury that was treated.
  2. Complete description of services rendered.
  3. List of charges for each service: there must be a separate charge shown for each service you received from the provider.
  4. Date of service for each service rendered.
  5. Location of service: if you received care in the doctor’s office — his/her address must be indicated.
  6. Specific name of doctor who treated you: many doctors practice together, therefore, you must indicate which doctor treated you, not just the corporation or clinic name
  7. Any other services or supplies received.