RETIREE AND MEDICARE Q&A

Q. Is there any restriction on the amount of sick time I can convert to get additional medical coverage?

A. No, the only restriction is you must convert at the rate of 120 NET sick hours to get an additional six month block of Medical, Dental, Optical and Prescription coverage.

Q. If I die will my spouse and children be able to use the balance of my converted sick time?

A. Yes, your spouse and children, up to 26 years of age, will be entitled to your medical coverage.

Q. If I am single and convert sick time and die before the time is used does the money go to my estate?

A. No, the City will keep the balance of your money.

Q. If I defer my coverage can I begin it at any time?

A. Yes, you have to notify the City of Philadelphia Board of Pensions and LEHB, in writing, when you want your coverage to start.

Note: coverage always begins on the first of the month.

Q. Does it make any difference if I retire on the 1st of the month or on the 28th of the month?

A. No, the month you retire in will be considered your last active medical eligible month. The beginning of the next month would be your first "pension medical coverage" unless you defer.

Q. I want to purchase extended medical coverage when I retire, how does that work?

A. By the FOP contract, Police Officers are able to utilize their NET Sick Leave to purchase additional medical, dental, optical and prescription coverage beyond their contractually guaranteed 5 years of post-retirement coverage. The first step is to convert GROSS Sick Leave hours to NET Sick Leave hours. Your time card reflects your GROSS Sick Leave accumulation. By contract, if you have 2499 hours or less, you can convert at 50%. That means that you are able to utilize ½ of your GROSS leave to either cash out or purchase additional medical coverage. If you have accumulated 2500 hours or more, you can convert at 60%. The number of NET Sick Leave hours required to purchase a 6 month block of extended coverage varies according to rank. HOWEVER, everyone, regardless of rank utilizes the same 120 hours of NET sick leave for 6 months of extended medical coverage, to determine the number of additional 6 month blocks they can purchase. Simply divide your total number of NET Sick Leave hours by 120.

EXAMPLE: A Captain retires with 4000 hrs. of GROSS Sick Leave.

1st. Step: Convert GROSS hrs. to NET hrs. **4000 x 60% = 2400**

2nd Step: Find the maximum number of 6 month blocks you can buy. **2400/120 = 20 blocks**

3rd Step: Determine the number of hours you must surrender for each 6 month block. This number is determined by your rank. The chart is located on page 38 of the FOP contract. For a Captain, 80 hrs is required. **20 blocks x 80 hrs. = 1600 hrs.** Therefore, the Captain would surrender 1600 NET Sick Leave hours to purchase 20 additional 6 month blocks (10 years). He/She would be paid for the remaining NET hours.

Q. What happens if convert an additional five years sick time for a total of 10 years medical coverage, which I start immediately, but within a month I find employment with lifetime coverage?

A. Once you informed the City to start your contractual five years medical coverage, along with any additional years by converting sick time, that coverage will continue to run until all time is expired.

Q. I'm not sure if my job is going to come through or if I want to apply for work are there any options?

A. Yes, inform the City of Philadelphia Board of Pensions you are deferring your coverage. Then contact LEHB and request the "90 day deferred program". Even though this will cost you a monthly premium, it will allow you time to obtain other employment with medical coverage without starting the City coverage.

Q. I understand that I should avoid the "medical gap" meaning my FOP five-year contractual medical coverage plus my conversion of sick time should be enough to get myself and my spouse on to Medicare, is that right?

A. That is absolutely correct. Since your pension never increases, if your LEHB coverage terminates prior to you and your spouse obtaining Medicare eligibility, it will cause severe financial problems trying to pay for quality medical coverage.

Q. I understand LEHB strongly suggests converting sick time to ensure affordable quality medical for myself and my spouse long into the future?

A. LEHB strongly recommends converting as much of your NET sick time as possible <u>without incurring a tax debt at the end of the year</u> to cover you and your spouse as far into the future as possible. This way, you would currently avoid any tax ramifications plus avoid the two single biggest problems in America today "quality medical coverage and how can I afford it"?

Q. How do I know if I qualify for Medicare? How about my spouse?

A. You can either call Medicare at 1-800-772-1213 or go to Medicare.gov on the web to check you and your spouse's eligibility.

Q. If I do not qualify for Medicare, can I obtain coverage on my wife's Social Security number? How about my ex-spouse's Social Security number?

A. Yes, if your spouse is at least 62-years-old and Medicare eligible and you are at least 65, and not Medicare eligible, you may apply on their Social Security number.

A. If you were married for at least 10 years, and divorced, you may qualify on your ex-spouse's Social Security number. Please contact Medicare to review your personal situation.

Q. Can you briefly explain Medicare? I understand there is a Medicare A, B and D.

A. Medicare A pays hospital related bills and is absolutely free to Medicare eligible members. Medicare B pays for medical surgery bills and currently cost most members $134.00 a month, per person.

A. Medicare D is Medicare prescription coverage which is normally included in medical plans. Note: the prescription coverage included in the medical plan must be equal to or better than Medicare D in order for it to be considered "credible coverage". Meaning you would not incur the 1% per month penalty for not taking Medicare D when you first became Medicare eligible.

Q. I understand there may be penalties imposed if I do not take Medicare when I first become eligible?

A. Since Medicare A is free, we strongly suggest you sign up when you are first eligible for Medicare. Medicare B imposes a 10% penalty for every year you do not take Medicare B when you first became eligible. This is an ongoing penalty and not just one time.
A. Medicare D imposes a 1% penalty a month for every month you do not take Medicare D when you first become eligible for Medicare. This is also an ongoing penalty.
A. Medicare B also has an "open enrollment" meaning you complete the Medicare application between January 1 and March 31, however, your medical coverage does not start until July 1.

Q. Can you please explain Medicare supplemental insurance?
A. Basically, Medicare pays 80% of all hospital and medical surgery bills so you need additional coverage often referred to as Medicare supplemental insurance. LEHB will be you and your spouse's supplemental insurance once you are Medicare eligible until your LEHB coverage terminates.

Q. How much is supplemental Medicare coverage?
A. Currently, for 2018, the highest rated Blue Cross supplemental coverage costs $377.85 for you and $377.85 for your spouse.

Q. Would you again summarize starting the medical clock and/or deferring coverage?
A. If you tell the City to begin your medical coverage, it will not stop until all time, including converted sick time, is exhausted.
A. If you defer your coverage, you simply move your block of medical coverage time back until you wish to reinstate which is always the beginning of a month.

Q. Could you please list the information I should obtain before going to the pension board making this lifetime medical coverage decision!
A. You should know the answer to the following questions:
Do you or your spouse qualify for Medicare?
What is the age difference between yourself and your spouse to ensure LEHB coverage until you are both Medicare eligible?
Am I going to become employed after I retire?
Does my spouse have medical coverage available? If so, I may want to consider deferring.

I now have Medicare. How do I know if Medicare or LEHB pays first?

Q. I am still an active police officer and on Medicare who pays my medical bills?
A. As long as you remain in active employment status, LEHB is your primary medical coverage.

Q. I just retired from the Police Department and now work for the school board with their medical coverage. Who pays my medical bills, the school board coverage, LEHB coverage or Medicare?
A. The school board coverage would be your active insurer since you are actively employed. They would be your primary medical insurance payer. What they do not pay, LEHB would supplement up to our level of benefits.

Q. I am an active Police Officer not yet eligible for Medicare but my spouse does have Medicare coverage. Who should I submit my spouse's medical bills to?

A. If your spouse does not have active medical coverage through their employer but does have Medicare as long as you remain an active employee and your spouse remains on your active medical policy, LEHB would be primary.

Q. If I retire from the Police Department and have Medicare and also have coverage on my spouse's active employment coverage, where would I submit my bills?

A. Since you are covered on an active employee policy, that policy would be financially responsible for your medical bills and your spouse's medical bills even though you have Medicare.

Q. I am now retired from the Police Department, not working, having no other active employment coverage, but have Medicare, who now do I submit my medical bills to?

A. Since you are retired Medicare becomes your primary insurer and LEHB becomes your Medicare supplemental advantage plan.

Q. I'm now retired from the Police Department, not working, no other active employment coverage. I understand Medicare is my primary insurer and LEHB is secondary but who covers my spouse's medical bills? My spouse is either not working or waived their coverage at work and not Medicare eligible.

A. LEHB would be the primary insurer for your spouse until they become Medicare eligible and retire from active employment.

Q. Even though my spouse and I have Medicare, if I am an active employee with medical coverage for myself and my spouse, whether it be with the Police Department or another employer, is that active coverage primary to Medicare?

A. Yes. As long as you or your spouse is covered under an active employee medical plan, that active coverage will be primary for both you and your spouse.

Q. If I am an active employee with coverage for myself and my spouse do I have to take Medicare B and pay $134.00 a month?

A. The key term is "retired". You may work to any age and not apply for Medicare B when first made available to you at 65 years of age. However, for example; when you retire at 72 years of age, you must apply for Medicare B and there will be no 10% annual penalties imposed. Nor will you be subject to the restrictions of open enrollment.
The same rule applies for your spouse.

Q. When my spouse and I are both retired, even though we still have LEHB medical coverage available for several years, must I apply for Medicare B?

A. That is our suggestion to protect you and your spouse. You do have the option of refusing Medicare B when it is first offered at 65 years of age but then you will incur a 10% penalty for every year you did not have Medicare B and be subject to a very strict open enrollment.

Medicare 101

In 1965, President Lyndon Johnson signed the original Medicare program into law
The program originally covered two portions:

- **Part A** - Hospital insurance
- **Part B** - Medical insurance

Part A covers a large portion of hospital-related costs for eligible people over the age of 65 and only includes medically necessary and skilled care, not custodial care. Persons not eligible for coverage can participate in the program if they pay a monthly fee

Part B is optional and pays a portion of non-hospital provided medical care, such as doctor visits and other outpatient services. There is a monthly fee for this program. The fee in 2017 is $134.00 for most people and is likely to rise in the future. Part B coverage is subject to various deductibles and co-pays.

The Medicare program still fulfills its original role, but was expanded in 1997 and refined in 1999 to include:

Part C - "Medicare" + Choice, now known as "Medicare Advantage"
Part C gives Medicare beneficiaries the opportunity to enroll in private healthcare plans and receive all Medicare services, including Part A and Part B, from a private provider. It operates like the healthcare coverage provided by most employers. A menu of offerings is available with a variety of coverage options, co-payments and monthly costs.
The private provider also covers services not provided by Parts A and B. Part C is available in most areas and provides a convenient way to receive medical services.
In 2006, the program expanded again to offer:

Part D - Prescription drug coverage
Part D is an optional insurance program that charges a monthly fee in exchange for prescription drug coverage. The monthly cost varies widely depending on the coverage options you choose. Like employer-provided health care plans, Part D holds an open enrollment session November 15 - December 31 each year, during which time program participants can choose to change their coverage options. While Part D is a voluntary program, Medicare recipients have to seriously review their healthcare needs immediately upon eligibility because the cost of Part D increases each year for individuals who choose not to participate *immediately* upon eligibility.

Although prescription drug coverage is particularly important for many senior citizens and Part D does help, the program has drawn heavy criticism. Many people find the array of coverage options and pricing to be particularly confusing. (To learn more about Medicare coverage options, see *Getting Through The Medicare Part D Maze*.)

What to Choose?

Participants in Medicare Part A and B can choose to participate in Part C and/or Part D, or they can choose to purchase supplemental insurance from a private carrier. This supplemental insurance, often referred to as "medigap" coverage, pays for expenses that are not covered by Medicare. Participants in Part C do not need to purchase medigap coverage because Part C enables them to select medical coverage that addresses most needs.

Medicare and Long-Term Care

The Medicare program is designed to provide for *medical care*, not the cost of long-term care (LTC). As such, Medicare's coverage for long-term needs is extremely limited. Assuming you qualify, Medicare may pay up to 100% of your costs in a nursing home for the first 20 days in a benefit period. Once 20 days have passed, you must pay a hefty co-insurance amount for days 21 through 100 for each benefit period. In order for Medicare to pay for your LTC costs at all, you must meet three criteria:

The 72-Hour Rule - You must have been hospitalized for at least three full days and three full nights. Many hospital stays are three days and two nights. For example, you might go in for a hip replacement on Monday morning and leave Wednesday afternoon.

Medical Necessity - Your care must fulfill the following requirements:
It must be medically necessary.
It must be care that can only be given in a nursing home, in most cases by skilled personnel.
It must result from the condition for which you were hospitalized.

Places Where Care Can Be Given - In almost all cases, patients leaving a hospital go straight to a nursing home for further care.

There's a difference between care that is skilled and medically necessary, and care that is custodial. The bottom line is determining whether you need assistance with activities of daily living (ADL) or custodial care. (For related reading , see *Taking the Surprise Out of Long-Term Care*.)

With some exceptions, Medicare pays for medically necessary skilled care in a nursing home setting. If you are homebound and need skilled care, Medicare may pay to have a caregiver come to your home to tend to your needs. Another exception is end-of-life or hospice care. The exact levels and locations for receiving skilled care vary from state to state.

Medicare is not designed to provide assistance with ADL or to provide assistance and aid to keep you in your home or in an assisted living facility. Providing funds for long-term care is the role of Medicaid and LTC. (To learn more about LTC and Medicaid, see *Long-Term Care Insurance: Who Needs It?*and *What's The Difference Between Medicare And Medicaid?*)

Conclusion

The rules and regulations covering Medicare can be difficult to understand, especially when it comes to needing assistance with ADLs or needing medical care. Not understanding the difference could cost you or your family dearly. Medicare may cost more and provide less in coverage and benefits than you may have thought. Investing time and energy into determining the best combination of coverage options can help you avoid unpleasant and expensive surprises down the road.

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