
2012 MEDICARE FACT SHEET
For
Employees and Retirees hired prior to July 1, 1997

Medicare is a federal health insurance program for people 65 or older, certain disabled people who are under the age of 65, and people of any age who have permanent kidney failure. The Health Care Financing Administration of the U. S. Department of Health and Human Services administers the program.

There are four parts to the Medicare program:

1. **Medicare Insurance Part A (hospital insurance)** helps pay a portion of the hospitalization cost, certain related inpatient care, skilled nursing facility care, hospice care, and home health services. This program is financed by payroll taxes, and if you are eligible based on your own or your spouse's employment. Usually you do not pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes and if you work fulltime for 40 quarters (10 years). For additional information about how you may qualify through a spouse, former spouse, or deceased spouse, contact the Social Security Administration (1-800-772-1213) or visit their website: (SSA.gov)
2. **Medicare Insurance Part B (medical insurance)** primarily covers medical necessary doctor's services, outpatient hospital care and other medical services. You pay a monthly premium based on your income which is deducted from your Social Security benefit. If you are not receiving a Social Security pension, the Social Security Administration will bill you directly.
3. **Medicare Insurance Part C (Medicare Advantage)** is a term used to describe the coordination between Medicare and a Medicare Advantage plan such as Kaiser Senior Advantage plan. Under this arrangement, you are required to assign your Medicare Part A, B, and D benefit to your HMO and to maintain that assignment. In return, your HMO will provide your benefits and will handle the coordination with Medicare.
4. **Medicare Insurance Part D (prescription drug insurance)** covers the cost of prescription drugs. HMO medical plans coordinate the Part D portion of your Medicare plan with the medical plan.

Pursuant to the *Agreements* with the bargaining units and other employee groups, you are required to sign up for Medicare Part B if you are eligible. Each retiree and every eligible dependent shall notify the District of his/her Medicare eligibility. **It is the sole responsibility of the retired employee and his or her eligible dependents to apply for and satisfy the requirements of Medicare.**

DISTRICT ENROLLMENT REQUIREMENTS FOR RETIREES

If you are District retiree enrolled in a District-sponsored medical plan after retirement, and you or any of your enrolled family members become eligible for premium-free Medicare Part A, the District requires you and eligible dependents to maintain Medicare Part B enrollment as soon as your family members become eligible for premium-free Medicare Part A, usually at age 65. If you are not eligible for premium-free Part A, you must send District a copy of the Social Security denial letter. **Failure to comply with these policies can result in penalties and the permanent loss of your District-sponsored medical coverage.** You must maintain continuous enrollment in Part B and have complied with District's Medicare requirements to be eligible for reimbursement. For Medicare enrollment and eligibility information, call Social Security at 1-800-772-1213.

A. MEDICARE RULE FOR RETIREES WHO RESIDE OUTSIDE OF THE US

Medicare generally does not cover health services outside the U.S. Therefore, the District 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. and if you are eligible for premium-free part A, you will be required to enroll in Part B. Medicare may charge a permanent higher premium if you enroll/re-enroll past age 65.

B. MEDICARE ELIGIBILITY AND PART B ENROLLMENT

The Social Security Administration (SSA), not the district, determines Medicare eligibility. Most people become eligible for Medicare

- At age 65, through their own work history or the work history of a current or former spouse,
- Before age 65, after receiving Social Security disability benefits for 24 months.

Medicare becomes available at the beginning of the month in which you turn 65, whether you are retired or still working. If you or your spouse are still working, and are covered by another employer's health plan, Medicare will always pay secondary to any other plan.

Non-working spouses may qualify for Medicare if the retiree meets the requirements for Medicare benefits. Retirees who are divorced, or surviving spouses who may otherwise not qualify on their own, will qualify for Medicare by being the ex-dependent of a qualified beneficiary. In either case, Medicare eligibility is based on a minimum age of 62 plus at least 10 years of marriage and a current un-married status. If you are not already receiving this benefit, check with the Social Security Administration (SSA) to see if you meet the requirements.

Employees Age 65 or Older

If you do not retire and continue working at the District past age 65, you are not required to sign up for Medicare Part B when you become eligible for premium-free Part A. Any family member covered by your plan who becomes eligible for Medicare may also defer signing up for Medicare. Federal law stipulates that your District plan be your primary coverage while you are working. It is your responsibility to contact Medicare ninety (90) days prior to retiring as you must immediately enroll in Medicare Part A and Part B when you stop work to avoid life-long Medicare penalties.

If you plan to retire in 2012, are eligible for retiree health insurance, and expect to enroll in Medicare during the year, consider whether the Medicare version of your medical plan offers the benefits you want. If not, Open Enrollment is the time to change plans. You will not be allowed change plans in mid-year simply because you have become eligible for Medicare or have elected to retire.

Medicare plan service areas may differ from non-Medicare plan service areas. The Medicare version of your medical plan may have different benefits, medical groups, specialists and behavioral health providers. Call the Plan directly or visit its website for more information.

C. WHO QUALIFIES FOR MEDICARE INSURANCE (PART B)?

Any person who is eligible for the premium-free Medicare Part A benefits may enroll for Part B. For 2012, the standard monthly Part B premium is **\$99.90** for most Medicare beneficiaries, a \$15.50 decrease over the 2011 premium of \$115.40. However, most Medicare beneficiaries were held harmless in 2011 and paid \$96.40 per month. The 2012 premium represents a \$3.50 increase for them.

If your income is above \$85,000 (single) or \$170,000 (married couple), then your Medicare Part B premium may be higher than \$99.90 per month. About 4 percent of current Part B enrollees are expected to be subject to these higher premium amounts

In 2012:

- Standard premium for beneficiaries who do **not** currently have the Part B premium withheld from their Social Security checks is **\$99.90**. i.e. CalSTRS
- Higher-income beneficiaries pay **\$99.90** *plus an additional amount*, based on the income-related monthly adjustment amount (IRMAA).

To determine your 2012 Part B premium amount, the Social Security Administration (SSA) use the most recent tax return information provided by the IRS. Generally, this information is from a tax return filed in 2011 (for tax year 2010). If unavailable, SSA will use income from three years ago. If you amended your tax return and it changes the income SSA calculate, you must appeal by sending SSA a copy of the amended tax return that you filed and acknowledgement receipt from the IRS.

If your income has fallen since 2010, the tax year used to determine your 2012 premiums, you may be able to reduce or eliminate your surcharge. To qualify, your income loss must be tied to a life-changing event such as marriage or divorce, a job loss or reduced working hours including retirement, loss of income-producing property, or cuts in pension benefits. The Medicare statute requires that the deductibles and premium be updated annually in accordance with statutory formula.

D. INCOME RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA)

The Internal Revenue Service supplies your tax filing status, your adjusted gross income, and your tax-exempt interest income to the Social Security Administration to determine if you have an income related monthly adjustment amount (IRMAA). The Social Security Administration will add your adjusted gross income together with your tax-exempt interest income to get an amount called the **Modified Adjusted Gross Income (MAGI)**.

The income-related monthly adjustment amount is effective from January 1 through December 31 each calendar year. The Social Security Administration will refigure your Medicare Part B premium amount again next year when the Internal Revenue Service updates the information.

For most beneficiaries, the government pays a substantial portion - about 75 percent of the Part B standard premium and the beneficiary pays the remaining 25 percent. However, the Medicare Modernization Act of 2003 (MMA) changed how Part B premiums are calculated for some higher income beneficiaries.

Since January 1, 2007, higher income beneficiaries have been paying a larger percentage of their Medicare Part B premium IRS based on income and filing status (Single/Head of Household or Qualifying Widow(er), Married/filing jointly, Married/filing separately) they reported the Internal Revenue Service (IRS). In 2012, higher income beneficiaries will pay a monthly premium equal to 35, 50, 65 or 80 percent of the total cost depending on what they reported to the IRS. Essentially, the MMA change reduces the government Part B subsidy from its current 75 percent for all beneficiaries to 65 percent or less for highest-income seniors.

The chart below shows the Part B monthly premium amounts based on income. These amounts change each year.

Table 1: Part B Monthly Premium Beneficiaries who are married, but file a separate tax return from their spouse and lived with his or her spouse at some time during the taxable year	
Your 2012 Monthly Premium is	Beneficiaries who are married but file a separate tax return from his or her spouse
\$99.90 - standard premium	\$85,000 or less
\$259.70 (Increased by \$159.80 due to IRMAA)	\$85,001-\$129,000
\$319.70 (Increased by \$219.80 due to IRMAA)	Above \$129,000

Table 2: Part B Monthly Premium		
	Beneficiaries who file an individual tax return with income	Beneficiaries who file a joint tax return with income
Your 2012 Part B Monthly Premium Is	If Your Yearly Income Is	
\$99.90 - standard premium	\$85,000 or less	\$170,000 or less
\$139.90 (Increased by \$40.00 due to IRMAA)	\$85,001-\$107,000	\$170,001-\$214,000
\$199.80 (Increased by \$99.90 due to IRMAA)	\$107,001-\$160,000	\$214,001-\$320,000
\$259.70 (Increased by \$159.80 due to IRMAA)	\$160,001-\$214,000	\$320,001-\$428,000
\$319.70 (Increased by \$219.80 due to IRMAA)	Above \$214,000	Above \$428,000

If your **M**odified **A**adjusted **G**ross **I**ncome (**MAGI**) in 2010 was greater than \$85,000 as reported to the IRS, the Medicare premium for Part B will increase accordingly. The maximum reimbursement rates for these individuals for calendar year 2012 are listed in the table below:

MAGI Range	Income Related Monthly Adjusted Amount (IRMAA)	Maximum Allowed for 2012
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Single, Head of Household, Qualifying Widow(er):

\$85,001 - \$107,000	\$ 40.00	\$99.90 + 40.00 = \$139.90*
\$107,001 - \$160,000	\$ 99.90	\$99.90 + 99.90 = \$199.80*
\$160,001 - \$214,000	\$159.80	\$99.90 + 159.80 = \$259.70*
Above \$214,000	\$219.80	\$99.90 + 219.80 = \$319.70*

Married, filing jointly:

\$170,001 - \$214,000	\$ 40.00	\$99.90 + 40.00 = \$161.50*
\$214,001 - \$320,000	\$ 99.90	\$99.90 + 99.90 = \$230.70*
\$320,001 - \$428,000	\$159.80	\$99.90 + 159.80 = \$259.70*
Above \$428,000	\$219.80	\$99.90 + 219.80 = \$369.10*

Married, filing separately:

\$85,001 - \$129,000	\$159.80	\$99.90 + 159.80 = \$259.70*
Above \$129,000	\$219.80	\$99.90 + 219.80 = \$319.70*

***If you pay a late-enrollment penalty, this amount will be higher. The penalty is not reimbursed by the District.**

What if my income has gone down? If your MAGI Range has changed at least one range since you filed your 2009 income taxes and you have experienced at least one of the qualifying events listed below, you should contact the local Social Security Administration (SSA) Office for a decision regarding your Medicare Part B premium:

- ◆ You married;
- ◆ You divorced or your marriage was annulled;
- ◆ You became a widow/widower;
- ◆ You or your spouse has stopped working or reduced work hours;
- ◆ You or your spouse lost income from income-producing property due to a disaster or other event beyond your control; or
- ◆ Your or your spouse's benefits from an insured pension plan stopped or were reduced.

At the end of each year, Social Security will send you a letter if your Part B premium will increase based on the level of your income and to tell you what you can do if you disagree. For more information about Part B premiums based on income, call Social Security at 1-800-772-1213.

E. WHO QUALIFIES FOR MEDICARE MEDICAL INSURANCE (PART C)?

Any person who is eligible for the premium-free Medicare Part A benefits may enroll for Part C via group coverage. The program is voluntary by law, but MANDATORY for District retirees who are Medicare recipients and insured under the Kaiser Senior Advantage Program. Typically, the program offers more comprehensive benefits in exchange for managed care.

As a Kaiser member you are required to enroll in **Senior Advantage**. This is a Medicare-risk plan and requires the participant to be enrolled in both Parts A and B of Medicare. Medicare pays a flat fee to the plan each month, and the HMO agrees to assume full responsibility for your care. Please note that District has integrated Medicare prescription drug plans into Kaiser HMO medical plan. If you are a retiree and are enrolled in Medicare Senior Advantage Plan through Kaiser, you do not need to purchase part D from any other source. The Senior Advantage Plan is identical to the District Kaiser Medical Plan. Failure to comply may disqualify you from all District paid benefits.

F. MEDICARE DOUBLE COVERAGE – An Important Reminder

The Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program, ruled that our historical practice of allowing Medicare members to receive Kaiser Permanent Senior Advantage benefits through more than one employer or trust contract is not allowed under law and regulations. While a Medicare beneficiary may be enrolled in a Medicare plan and a commercial plan at the same time, he/she *may not be enrolled in more than one Medicare Plan at a time*. Therefore, you may not enroll as "double-covered" Medicare member at any time; you must designate the District coverage as your Medicare Plan of Record.

G. MEDICARE PART D CREDITABLE COVERAGE

The Foothill-De Anza Community College District has determined that the prescription drug coverage offered by the District is, on average for all plan participants, expected to pay out as much or more than the standard Medicare Part D benefit.

Since the existing coverage is on average at least as good as or better than the standard Medicare prescription drug coverage, you may keep the District coverage. If you decide later to enroll in Medicare Part D coverage, you will not be penalized.

Please note: If you choose to enroll in a Medicare drug plan, you will jeopardize your group health plan coverage and the District will not reinstate your coverage at a later date.

Other Employer or Retiree Plans: If you have health insurance with another employer or retiree plan, you may wish to contact them and inquire about their rules regarding enrollment in Medicare Part D plans. ***Under Medicare rules, you may be enrolled in only one Medicare Part D plan.***

H. WHEN AND HOW TO ENROLL FOR MEDICARE:

Sign up for Medicare Part A three (3) months prior to your 65th birthday.

Enroll in Medicare Part B when:

- ◆ You are 65 or older; and
- ◆ Your or your spouse's current employment ends, *or*
- ◆ Your coverage under the employer group health plan ends, whichever comes first.

Failure to enroll in a timely manner will cause the premium for Part B to increase by as much as 10% per year for each year that you fail to sign up. However, if you or your spouse are still actively employed full-time and eligible for benefits with another employer's health plan (other than the District's Medical Plan) at the time you turn 65, you may delay enrollment without penalty.

CALIFORNIA STATE TEACHERS' RETIREMENT SYSTEM (CalSTRS) MEDICARE PREMIUM PAYMENT (MPP) PART A PROGRAM AND ELIGIBILITY REQUIREMENTS: Teachers' Retirement Law (section 25940) – Program discontinues effective July 1, 2012.

Faculty hired after April 1, 1986 have been required to pay into Medicare. Faculty hired prior to April 1, 1986 did not pay into Medicare, but CalSTRS enabled faculty to become Medicare eligible through its California State Teachers' Retirement System MEDICARE PREMIUM PAYMENT (MPP) PART A program.

Under the MPP Program, beginning July 1, 2001, CalSTRS agreed to compensate the Medicare Part A (hospitalization) premium for those eligible Defined Benefits (DB) Program members who are not qualified for premium-free Part A benefits through their own employment or that of a spouse.

The MPP program initially agreed to cover certificated employees who retired prior to January 1, 2001 and later extended through July 1, 2012, but eligibility was limited to those retiring from a district that held, or was in the process of holding, a Medicare Division Election prior to their effective date of retirement. The Teachers' Retirement Board has the authority to extend the retirement eligibility date for the program.

The District's Medicare election was held February 18-28, 2003. Therefore, *faculty who retired between January 1, 2001 and February 18, 2003 are not eligible for premium-free Medicare coverage through the STRS program.*

For those retiring after the Medicare Election, MPP coverage depends on the following:

- Faculty age **58 or older** at the time of the election (February 28, 2003) automatically become Medicare-eligible at age 65 regardless of whether they voted "Yes" or "No," provided they retire before July 1, 2012.
- Faculty age **57 or younger** at the time of the election (February 28, 2003) AND retire before July 1, 2012 automatically become Medicare-eligible contributions until retirement to become Medicare-eligible at age 65. Under the MPP program, you will become Medicare eligible even if you pay into Medicare for fewer than 40 quarters. Medicare STRS agreed to pay the difference between the number of quarters earned and the 40 quarters normally required.

For those who qualify for the MPP program, CalSTRS will pay your Medicare Part A premium (standard rate of \$451/mo for retirees with less than 30 credits or \$248/mo for retirees with 30-39 credits). *CalSTRS deducts Medicare Part B premiums from retirement or disability allowances.* Premiums and assessments are forwarded to the Centers of Medicare & Medicaid Services (CMS). This benefit is not available to a member's spouse or beneficiary (ies). CalSTRS can deduct Medicare Part B premium from your monthly retirement benefit and forward the payment to Medicare.

You must contact *CalSTRS Health Benefits, P. O. Box 15275, MS #47, Sacramento, CA 95851-0275, Member Services at 1-800-228-5453 (M-F 7am-6pm) or email CalSTRS at www.calstrs.com* to request a CalSTRS Medicare Payment Authorization Form to pay your Medicare Part A premium and authorize deduction of the Medicare Part B premium from your monthly benefits.

NOTE: CalSTRS will not pay Medicare penalties for late enrollment in Medicare Part A or B.

I. MANDATORY MEDICARE ENROLLMENT FOR ALL RETIREES

Certificated Employees, who retired under **Article 19** and continue to teach part-time at the District until full retirement, and **regular faculty retirees** who may have **never contributed into Social Security**, **must** check with the local Social Security Administration Office to verify eligibility. If eligible, the retiree **must** sign up for both Medicare Part A & B for **dual coverage** with Medicare as **primary** and the District's medical plan as **secondary**. If you do not have enough credits and are ineligible for Medicare due to age limits (less than 65 years of age), you do not have to do anything. You remain covered under the District's medical plan as **primary** until you qualify.

Please note that *participation in the CalSTRS Medicare Premium Payment Program (MPPP) is **mandatory** for eligible certificated retirees who retire prior to July 1, 2012. Retired CalSTRS members who qualify for this benefit must enroll in Medicare through the Social Security Administration. CalSTRS may pay and deduct Medicare premiums for CalSTRS members only. **Failure to comply with this policy can result in the permanent loss of your district-sponsored medical coverage.***

*If a retiree chooses to delay signing up for a Social Security pension for financial reasons when eligible, he/she is still required to enroll for Medicare Parts A and B at the age of 65 or at the time of eligibility. **Failure to do so will forfeit his/her District paid benefits.** If you do not claim a social security pension, the monthly Medicare premium Part B will be **billed quarterly** directly to you by Medicare and must be **paid directly by you.** If you elected not to have Medicare premium part B deducted automatically against your social security pension (when eligible) or to have the premium billed quarterly, the district will only reimburse you a monthly premium of **\$99.90** (unless you are impacted by M.A.G.I.).*

Failure to sign up for Medicare in a timely manner will increase the premium for Part B and will result in loss of Medicare benefits as PRIMARY carrier effective the date of Medicare eligibility. The District plans required Medicare Crossover set up with CMS prior to processing your claims as Primary. It is imperative that this notice is completed prior to the date of Medicare eligibility. The District plan will not pay your claims as PRIMARY simply because you enrolled late, Medicare must process all claims first. You are responsible for the full cost any medical claims incurred that is not are not coordinate with Medicare as PRIMARY. The District's Medical Plan requires a copy of the **Medicare Explanation of Benefit (E.O.B.) statement** in order to coordinate benefits and process your claim(s) as secondary payment.

For more information on how to enroll in Medicare, premium amounts, or premium surcharges, contact SOCIAL SECURITY ADMINISTRATION at **(800) 772-1213** from **7:00 a.m. - 7:00 p.m.** or www.socialsecurity.gov.

L. MEDICARE PROVIDERS REQUIRED:

To receive plan benefits under all district-sponsored Medicare plans, you must use a provider who participates in Medicare. If your doctor does not take Medicare patients or will only render services under a "private contract" directly with you, neither Medicare nor your district-sponsored medical plan will cover the services. If your doctor takes non-Medicare patients but not Medicare patients, you may need to select a new doctor when you become eligible for Medicare.

M. SPOUSE AND DOMESTIC PARTNER COVERAGE:

District paid health benefits are for the lifetime of the eligible retiree only. If you predecease your spouse/domestic partner, he or she will not be eligible to continue to receive District-paid health benefits. However, he or she may purchase continuation health benefits through the District provided that your survivors qualified for post-retirement survivor continuance through either CalPERS or CalSTRS, and your spouse (if you have been married at least one full year before retirement and remain continuously married until your death) or your same-sex domestic partner (if your partnership began at least one full year before retirement and continues uninterrupted until your death).

The postretirement survivor continuance is not optional, and you may choose the recipient. During your election interview, your Benefits Representative will ask for information on your family members to include on your election form. This information is used to determine eligibility for the postretirement survivor continuance. Please be advised that you forfeit postretirement survivor continuance if you elect a lump sum cash-out or option 1, you waive all rights to continue contingent annuitant benefit.

REMINDER: Only dependents **insured** through the District program are eligible for Medicare premium part B reimbursement.

You may use www.MyMedicare.gov to (1) View claim status, (2) Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card, (3) View eligibility, entitlement and preventive services information, (4) View enrollment information including prescription drug plans, (5) View or modify your drug list and pharmacy information, (6) View address of record with Medicare and Part B deductible status, and (7) Access online forms, publications and messages sent to you by Center of Medicare and Medicaid Services (CMS).

N. MEDICARE COORDINATION OF BENEFITS FOR MEDICARE BENEFICIARIES

By law, Medicare is the PRIMARY Payer for retirees' medical and prescription drugs expenses. The District Medical Plan is the SECONDARY payer. To ensure timely payment from the Third Party Administrator and coordination of benefits via Medicare Crossover Program for the retirees, **you must provide to the District copies of the Medicare ID card, "Medicare Determination Letter" or "Medicare Award Letter", and/or proof of Medicare premium payment when eligible.**

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER
000-00-0000-A
SEX
FEMALE
IS ENTITLED TO
HOSPITAL (PART A)
MEDICAL (PART B)
EFFECTIVE DATE
07-01-1986
07-01-1986
SIGN HERE → *Jane Doe*

We strongly recommend that **your notification to the district to be completed by the first of the month of Medicare eligibility to guarantee that Medicare adjudicates claims properly as primary.** If you are late in notifying the district, CMS reserves the rights to refuse processing your claims due to late Medicare Crossover notification. To that end, the district plan would not pay any of your outstanding claims as primary until Medicare processed the outstanding claim(s) as primary first. If the Plan inadvertently paid your claims as primary, we reserve the rights for full recovery. Consequently, you will be responsible for the full cost of any medical expenses incurred during this period.

If you have any questions regarding MEDICARE ELIGIBILITY and PART B - QUARTERLY PREMIUM REIMBURSEMENT, please contact the Benefits Unit via email: MyBenefits@fhda.edu.

O. MEDICARE PREMIUM REIMBURSEMENT:

The District will reimburse retired employees and eligible dependents for the cost of optional Medicare, Part B on a quarterly basis (March, June, September, and December). For 2012, the standard reimbursement rate for Medicare Part B premium is **\$99.90** for most beneficiaries.

What is New? Starting January 1, 2012, members who submitted proof(s) of Medicare Part B payment to the District by March 15th will be eligible to receive the first quarter reimbursement (January – March premium) on April 15th. Proofs of payment received by the District between *March 16-31* will be processed along with the Second Quarter payment (April –June) for checks distribution scheduled on July 15 to include refund for the first 6 months (January-June). There shall be no retroactive payment for late notice.

P. TO APPLY FOR MEDICARE REIMBURSEMENT

You must submit PROOF OF PAYMENT to the Office of Human Resources to be reimbursed for Medicare premiums. Submit a copy of the following forms **annually** (paper size 8 X 11 only please). **The form must indicate the recipient name, social security number, the effective date of Medicare coverage and monthly premium amount. New enrollees must notify the District within the first month of coverage, as there will be no retro payment:**

- 1) If you have Social Security Income and/or Supplemental Security Income (SSI) and are qualified for Medicare, you may request **ONE** of the following statements at any time by calling your local Social Security Office:
 - a. "Proof of Income" Letter or "Proof of Award" Letter from Social Security. You may request the form online via <http://ssa.gov/onlineservices/>. (It may take up to 10 days for delivery); or
 - b. Form SSA-2458 (Report of Confidential Social Security Benefit Information); or
 - c. Form SSA-4926 SM Statement (Notice of new monthly Medicare Premium) also known as "Your New Benefits Amount" Statement; or

- d. Current 2012 STRS Monthly Pension Statement, which includes monthly Medicare Part B premium deduction for 2012.
- 2) If there are any changes in premium rates, retirees are required to submit a copy of the form letter from Social Security that notifies you of an increase in Medicare premium during the course of the year. Generally, rates changed every January.
- 3) If you do not qualify for Social Security income, but qualify for Medicare and pay premiums directly, you need to submit one of the following:
 - a. A copy of the 2012 quarterly invoice statement (CMS 500) from the Social Security Office for the current year, plus the most recent bank or credit card statement showing the current premium for Part B charged against your account (You may redact any other personal financial information); or
 - b. A Bank Certification Letter confirming the CMS' Electronic Fund Transfer (EFT) was debited against your checking or saving account.

For first time Medicare recipient under this provision, we strongly recommend that you pay for the first invoice with a **bank cashier check** to obtain immediate proof of payment as time is of the essence. Thereafter, you may set it up for electronic fund transfer via ACH process with your local bank and CMS to pay for future Medicare Part B premium.

NOTE: Form SSA-1099 and 1042S statements are NOT accepted as proofs of payment.

All **newly eligible Medicare beneficiaries** are reminded that there will be **NO RETRO PAYMENT** to anyone who submits late notice(s) regarding their MEDICARE eligibility to the District. **Reimbursement will become effective during the month in which the District receives your notice.** For example, if you become eligible for Medicare Part B on March 1, 2012 and the District does not receive your notice until April 15, 2012, your reimbursement will become effective April, 2012, not March, 2012. This provision **does not apply to any existing Medicare participants** who have been qualified to receive reimbursement through the District prior to January 1, 2012.

Action Required for NEW Medicare Participants:

1. Provide a copy of the Center of Medicare and Medicaid Services (**CMS**) **Determination "AWARD" Letter** which indicates Name, SSN, date of Medicare eligibility, Medicare Part B monthly premium for 2012
NOTE: For non-Social Security pensioner, you may submit a copy of the **cashier check** that you use to pay for the first quarterly Medicare Part B premium and the initial Medicare Part B invoice as proof of payment in lieu of the above CMS Award Letter.
2. Provide a copy of **Medicare ID card(s) for both Retiree & Spouse/Domestic Partner**
3. Return the paperwork to the District Human Resources Office **no later than the last day of the month that you became eligible for Medicare** to avoid incurring loss of Medicare part B premium reimbursement.

NOTE: It is imperative that you notify the District immediately upon qualifying for Medicare. You must submit proof of Medicare eligibility and payment in a timely manner. **Reimbursement is not retroactive.**

Please submit your proof of Medicare payment to:

**FOOTHILL - DE ANZA COMMUNITY COLLEGE DISTRICT
ATTN: BENEFITS UNIT
12345 EL MONTE RD
LOS ALTOS HILLS, CA 94022**

TEL: (650) 949-6224 E-Mail: MyBenefits@fhda.edu FAX: (650) 949-2831