November 2015

TURNING 65
MEDICARE AND YOU

In 1968, the WGA established the Writers' Guild-Industry Health Fund (Health Fund) to provide its members with health coverage tailored to the unique concerns of its members working in the entertainment industry.

The Health Fund resolved that if a writer is able to retire with 68 qualified quarters (for those retiring on or after January 1, 1997) of employment they will be categorized as a "Certified Retiree" and receive the full benefits of the Health Fund from the age of 60 through to 65 – at which point under federal law Medicare can come into effect.

Once a Certified Retiree is 65 and enrolls in Medicare Parts A and B, Medicare becomes the primary health carrier (i.e., pays first). The Health Fund coordinates with Medicare so that the writer receives comparable benefits to when the Health Fund alone was providing coverage.

The Medicare guide which follows is intended to help you understand how Medicare and your Health Fund coverage work together, and how you might take advantage of all the resources available to you.

If you are not a Certified Retiree, there are still many viable options available to you, as explained throughout this guide, and in even greater detail throughout our website: www.wgaplans.org

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Turning 65 (Medicare And You)

MEDICARE AND YOU

This user guide will help you better understand how to maximize benefits through Medicare.

THE VERY FIRST THING YOU SHOULD DO:

Before you turn 65…

ENROLL IN MEDICARE!

Even if you are receiving health insurance from the Writers' Guild-Industry Health Fund, even if you are not yet receiving Social Security, with very limited exceptions, you should enroll in Medicare!

DON'T WAIT. ENROLL!

If you still have questions after reading this guide, please call us at (818) 846-1015 and we will be happy to assist you.

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I. GETTING STARTED – THE BASICS

Medicare is a federal health insurance program for people age 65 or older, people under 65 with certain disabilities and people of any age with End-Stage Renal Disease (ESRD). Every paycheck you earned in your working life had money taken out of it so you could have Medicare – you paid a lot of money for these benefits!

If you are a Certified Retiree and enroll in Medicare Parts A and B, Medicare becomes your primary health carrier (i.e., pays first). The Health Fund coordinates with Medicare so that you receive comparable benefits to when the Health Fund alone was providing coverage. The Health Fund will continue as the sole plan for your prescription drugs unless you opt to pay for Medicare drug coverage.

Federal law places Medicare in a secondary position (i.e., pays second) if you are still working and receiving health coverage through your current employer (or your spouse's), and the employer has 20 or more employees.

If you are not a Certified Retiree, you will want to enroll in Medicare Part A and Part B when you first become eligible at 65. If you are still working after age 65 – and have employer-provided coverage – you will enroll when you are no longer receiving employer-provided coverage, during your Special Enrollment Period (explained in more detail later in this guide). You may want to consider a Medicare Advantage program, commonly referred to as Medicare Part C; Medicare Part D, which covers prescriptions, may also be of interest to you. There will be more information about this later.

In addition to reading this guide, you can get government-provided information, including the official U.S. government Medicare Handbook, *Medicare & You (2016),* from:

www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

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THERE ARE FOUR PARTS TO MEDICARE:

MEDICARE PART A Covers hospitalization, hospice, and home health care (more about this in Section III). If you are a Certified Retiree, optimize your coverage and reimbursements for hospital and doctor bills by enrolling in Medicare.

MEDICARE PART B Covers outpatient services like doctor visits (more about this in Section III).

MEDICARE PART C Medicare Advantage Plans (commonly called Medicare Part C) are Medicare approved Plans available through private companies (more about this in Section III).

MEDICARE PART D Covers prescription drugs (more about this in Section III).

HOW MEDICARE PARTS A THROUGH D APPLY TO YOU AS A WRITER

As you approach age 65, Medicare Parts A, B, C, and D are each relevant, depending on your individual circumstances. As a writer, you most likely will fall into one of the following categories and should consider carefully the actions you need to take:

EARNED COVERAGE If you (or your spouse) have healthcare coverage as a result of being currently employed, you may want to apply only for Medicare Part A coverage.

A writer who is currently employed and receiving health coverage from that employment may want to enroll only in Medicare Part A.

The earliest possible time to apply for Medicare Part A is three months before the month of your 65th birthday.

Because your healthcare needs may be covered by your primary carrier as long as you or your spouse continues to receive health coverage from employment, it might be to your advantage to delay Part B (and Parts C and/or D) enrollment.

If you are still working when you reach age 65 and do not enroll in Part A and/or Part B when first eligible because you have employment-based coverage (your

own, your spouse's, or, if disabled, a family member), you can enroll in Part A and/or Part B without paying a penalty any time you are still covered by that group health plan. If you do enroll at that time, you will have to pay premiums for both your employer-provided coverage and any Medicare Part B coverage (Part A is free).

If you don't enroll in Medicare Part A and/or Medicare Part B while you have employment-based coverage, once that coverage ends, you will need to enroll during the 8-month period that begins the month after the employment ends or the coverage (not including COBRA coverage) ends, whichever happens first, in order to avoid penalties and increased costs. This is referred to under Medicare as a Special Enrollment Period. If you are not a Certified Retiree who qualifies for health benefits, you may want to examine Medicare Part C and Medicare Part D. (There will be more about this later.)

EXTENDED COVERAGE PROGRAM If you are receiving health coverage because you are using Extended Coverage points, you may want to opt solely for Medicare Part A until your Extended Coverage points are exhausted. The reason for this is that while you are receiving health insurance via Extended Coverage you may not have need for Medicare Parts B, C, or D.

Once your health coverage from employment (or Extended Coverage points) ends, Medicare becomes the primary carrier. It is critical to keep this in mind, and to make plans to enroll in Medicare Part A and Part B, and to pay your Part B premium as soon as possible in the Special Enrollment Period at the conclusion of employment-based coverage in order to avoid penalties and increased costs. (For further explanation, see chart in Section IV)

As long as you are using Extended Coverage points, you may want to enroll in Medicare Part A only.

Once the Extended Coverage points are used up, you will want to enroll in Medicare Part B.

CERTIFIED RETIREE If you and/or your spouse are a Certified Retiree* under the Health Fund and you (or your spouse) are not covered by employer-provided health insurance, it is necessary to enroll in Medicare Part A and Medicare Part B in a timely manner in order to avoid paying late enrollment penalties and increased costs. You may not want to enroll in Medicare Parts C or Part D if your health care needs that would be covered by Medicare Parts C and D are already

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be covered by the Health Fund. (See item #5 in the FAQ section of this document for more information)

A Certified Retiree is a Plan participant who has retired under the Pension Plan and at the time of retirement has a minimum of 68 qualified quarters (for those retiring on or after January 1, 1997) of Health Fund coverage. Certified Retiree Health Fund coverage does not become effective until the Certified Retiree is at least 60 years of age.

RETIREMENT BEFORE REACHING CERTIFIED RETIREE STATUS It is important that you carefully consider your options before retiring with the PWGA Pension Plan. If you file for retirement with the PWGA, and you have not accumulated enough qualified quarters to become a Certified Retiree (68 quarters), you will not receive Certified Retiree health coverage from the Health Fund even if you earn 68 quarters at a later date.

If you elect to retire before you acquire 68 qualified quarters, you should apply in a timely manner for both Medicare Part A and Part B in order to avoid paying late enrollment penalties. You may also want to consider a Medicare Advantage program and/or Medicare Part D as soon as you turn 65.

It is particularly critical that you fully understand the consequences of electing to retire if you fall into one of these categories.

WORKING BUT NOT YET A CERTIFIED RETIREE If you are still working and have Earned Coverage you may opt not to retire. In this circumstance, when you are first eligible you may want to enroll in Medicare Part A only. Medicare Parts B, C, and/or D may not be necessary because your healthcare needs may be covered by your primary carrier as long as you or your spouse continues to receive health coverage from employment.

If you decide to retire anyway (which would make you a Non-Certified Retiree), you may still want to opt for Medicare Part A only when you are first eligible, and then file for Medicare Part B in a timely manner when you are no longer receiving Earned Coverage in order to avoid increased penalties.

SOCIAL SECURITY If you are collecting Social Security benefits (even if you are still working), you will automatically be enrolled in Medicare Part A and Part B starting the first day of your birthday month. (If your birthday is on the first day of the month, then Part A and Part B will start the first day of the prior month.) If you are automatically enrolled, you should receive your Medicare ID card in the mail 3 months before your 65th birthday. If you are going to wait to enroll in Part

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B, then follow the instructions that come with the Medicare ID card and send the card back. ***If you keep the card, you keep Part B and will pay Part B premiums.***

If you are receiving health coverage through the Health Fund as a Certified Retiree, you should enroll in Medicare Part A and Part B when first eligible in order to avoid penalties and increased costs. Once you enroll, at your request, the Part B premium will be deducted from your Social Security check automatically.

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II. FAQs – QUESTIONS AND ANSWERS

1) **WHEN I RETIRE, DON'T I GET HEALTH COVERAGE THROUGH THE WRITERS GUILD INDUSTRY HEALTH FUND?** If you have 68 qualified quarters (for those retiring on or after January 1, 1997) when you retire and begin drawing your pension, you will be considered a Certified Retiree. The Health Fund will be your primary healthcare carrier from 60 until 65, at which time the federal health insurance Medicare program becomes available and is treated as your primary coverage – when this happens, the Health Fund moves into a secondary position. (There is no Certified Retiree coverage before age 60.)

2) **HOW DOES A WRITER BECOME A CERTIFIED RETIREE?** For every year you qualify for healthcare coverage you accrue four quarters toward your Certified Retiree status. Once you reach 68 qualified quarters (for those retiring on or after January 1, 1997), when you opt to take your pension you are considered a Certified Retiree and can receive health coverage beginning at age 60. (Note: Before 1988, there were different criteria for accruing points. For more information about this, see the Health Fund Summary Plan Description (SPD) – available at our web site: www.wgaplans.org)

3) **IF I WANT TO ENROLL IN MEDICARE PART A AND PART B WHEN I TURN 65, WHAT ARE THE TIME LIMITS FOR WHEN I HAVE TO APPLY?** If you are not yet receiving Social Security benefits, you should apply three months before the month of your 65th birthday (Technically, you have until three months after the month of your 65th birthday to enroll, but if you enroll during the month in which you turn 65 or the three following months, the start date for your Medicare coverage will be delayed). You can apply online if you meet certain requirements. Here is the link to enroll on-line: https://secure.ssa.gov/iClaim/rib

   You can find answers to questions about the online application here: https://www.socialsecurity.gov/medicare/apply.html

Failing to enroll in Medicare in a timely manner costs you money – twice! Once when you have to pay medical costs that might have been covered if you had enrolled on-time and once again when you have to pay an increased monthly Medicare premium for enrolling late.

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4) **IF I'M A CERTIFIED RETIREE AND I'VE ALREADY GOT HEALTH COVERAGE, WHY DO I WANT TO ENROLL IN MEDICARE?** The Health Fund covers Certified Retirees as the primary carrier until they are 65, at which point Medicare becomes your primary health insurance carrier. This means that the Health Fund coordinates with Medicare so that you receive comparable benefits to when the Health Fund alone was providing coverage unless you are working and your employer provides health insurance – in which case Medicare will be the secondary carrier.

5) **WHAT HAPPENS IF I DON'T ENROLL IN MEDICARE?** If you are a Certified Retiree when you turn 65, Medicare becomes your primary health insurance carrier and the Health Fund moves into a secondary position. Even if you have not enrolled in Medicare, the Health Fund will pay its portion of the costs as if you are enrolled in both Part A and Part B, and will coordinate benefits as if you had received reimbursement for your medical expenses from Medicare. You will have to pay the difference between what the Health Fund pays and what Medicare would have paid if you had enrolled in Medicare.

If you are a Certified Retiree and fail to enroll in Medicare Parts A and B, you will be fully liable for the medical costs that Medicare would otherwise have paid.

As you will see below, that can be a lot of money:

Certified Retiree with and without Medicare Comparison	**Certified Retiree** (enrolled in Medicare)	**Certified Retiree** (not enrolled in Medicare)
Multiple office visits (OOP not met)	**$120.00**	**$950.00**

(In this example, failure to enroll in Medicare Part B cost the participant an extra $830)

Certified Retiree with and without Medicare Comparison	**Certified Retiree** (enrolled in Medicare)	**Certified Retiree** (not enrolled in Medicare)
Single surgery (OOP not met)	**$164.51**	**$29,226.64**

(In this example, failure to enroll in Medicare Part B cost the participant an extra $29,062.13)

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Certified Retiree with and without Medicare Comparison	Certified Retiree (enrolled in Medicare)	Certified Retiree (not enrolled in Medicare)
Single surgery (OOP met)	**$0.00**	**$2,632.42**

(In this example, failure to enroll in Medicare Part B cost the participant an extra $2,632.42)

You can find the details for how these three examples were calculated by going to www.wgaplans.org

6) **IS MEDICAL CARE MORE EXPENSIVE IF MEDICARE IS MY PRIMARY CARRIER?** If, as a Certified Retiree, you enroll in Medicare when eligible, there typically is little – if any – difference in cost to the writer when Medicare is the primary carrier and the Health Fund is secondary. You can find further details on the web site at: www.wgaplans.org

   Certified Retirees who are entitled to benefits under Medicare, whether or not they enroll, will be deemed to have enrolled for purposes of determining which plan is primary and what benefits are payable by the Health Fund.

7) **HOW DOES THE HEALTH FUND PAY BILLS WHEN I HAVE MEDICARE?** The Health Fund coordinates your benefits with Medicare so that the combined medical payments of Medicare and the Health Fund are equal to – but not more than – what the Health Fund would have paid if Medicare were not involved.

8) **I AM WORKING AND I AM OVER 65. WHY ISN'T MEDICARE MY PRIMARY CARRIER?** If you are working AND your employer provides you health coverage even though you are drawing your pension, then Medicare becomes the secondary carrier for as long as you're actively employed and have health coverage.

Medicare is not automatically notified that you are no longer receiving health coverage from an employer.

You must enroll in Medicare Parts A and/or B when your employer-provided health coverage ceases in order to avoid late enrollment penalties.

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When you continue to work and receive health coverage as a consequence of that employment, Medicare regards you differently than if you were retired and not working.

9) **SO, IF I'M WORKING AFTER AGE 65 AND GETTING HEALTH INSURANCE COVERAGE AS A RESULT, DO I STILL NEED TO ENROLL IN MEDICARE WHEN I TURN 65?** If you fail to enroll in Medicare Part A before the deadline (unless you qualify for a Special Enrollment Period), you will be liable for uncovered medical costs, and you will also pay a 10% penalty in additional premium payments for every 12-month period that you fail to enroll. You'll have to pay the higher premium for twice the number of years you could have had Part A, but weren't enrolled in the program.

   It might be to your advantage to delay Part B (and Parts C and/or D) enrollment because your healthcare needs may be covered by your primary carrier as long as you or your spouse continues to receive health coverage from employment. If you want to ensure there is no possibility of error, you can enroll in Part A and/or B any time you are still covered by the group health plan or during your Special Enrollment Period (discussed in more detail later).

10) **WHAT IF MEDICARE IS MY PRIMARY CARRIER AND THEN I GO BACK TO WORK?** Once you are receiving health insurance from your employer, Medicare moves into a secondary position until your employer-provided coverage ends.

11) **HOW DOES HAVING MEDICARE IN THE POSITION OF PRIMARY CARRIER AFFECT WHAT I HAVE TO PAY?** There is usually little – if any difference – in cost to a writer when Medicare is in the primary position and the Health Fund is in second. (Note: If your doctor doesn't accept Medicare, then the costs to you will be significantly higher. There is a detailed explanation of this in our on-line Medicare Users Guide in Section VI). There is usually little – if any – difference in cost to a writer when Medicare is in the primary position and the Health Fund is in second.

   (Note: If your doctor doesn't accept Medicare, then the costs to you will be significantly higher. There is a detailed explanation of this at the web site: www.wgaplans.org.)

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Below are two examples of typical costs when Medicare is the primary carrier and the Health Fund is in a secondary position (Active Earned means you are receiving health coverage as a result of employment):

Certified Retiree and Active Earned Comparison	**Certified Retiree** (enrolled in Medicare)	**Active Earned** (no Medicare involvement)
Provider's Billed Amount	$125,133.89	$125,133.89
Participant's payment to the provider	**$1,100.00**	**$1,100.00**

(In this example, there is no difference in cost to the participant)

Certified Retiree and Active Earned Comparison	**Certified Retiree** (enrolled in Medicare)	**Active Earned** (no Medicare involvement)
Provider's Billed Amount	$305.00	$305.00
Participant's payment to the provider	**$38.30**	**$24.45**

(In this example, the participant pays $13.85 more as a Certified Retiree)

If you would like to know the details of how these calculations were made, please go to www.wgaplans.org.

12) **HOW DOES MEDICARE WORK IF I GO BACK AND FORTH BETWEEN WORKING AND UNEMPLOYMENT?** The simplest explanation is this: After age 65, when you are working and receiving health coverage from that employment, Medicare moves to the secondary position, and the coverage from employment is primary. When you are not receiving health insurance from employment, Medicare is the primary carrier.

While you are working and receiving health coverage from that employment, you may notify Social Security that you do not wish to pay Part B premiums. If you elect to go this route, you will not be penalized, but you must be very careful to renew Part B when you are no longer receiving health coverage from employment.

There is a Special Enrollment Period of eight months that begins the month after your employment ends or you are no longer receiving health insurance from your employer (whichever happens first) in which to enroll.

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To avoid late enrollment penalties, make sure you apply and pay for Medicare Part B during your Special Enrollment Period. If you fail to make a payment during the allotted eight-month time frame, it will be the same as if you had never enrolled. You will have to wait until the following year during the General Enrollment Period to enroll, and you will incur a permanent 10% premium penalty for every year you delay.

In addition to the Medicare premium penalty and the loss of health coverage protection you are entitled to, if you fail to enroll in Medicare, Fund benefits will be reduced as if Medicare had paid its portion. (See the web site at www.wgaplans.org for detailed for examples)

When a non-certified retiree transitions from employer-provided health coverage to full-time Medicare coverage, Medicare treats the time period(s) in which you apply for Medicare Part B differently depending upon how soon you apply. It works like this:

TIME PERIOD IN WHICH MEDICARE PART B IS REQUESTED	MONTH COVERAGE BEGINS
1st THREE MONTHS WITHOUT EMPLOYER PROVIDED HEALTH COVERAGE	Part B coverage starts the same month it is requested.
4th THROUGH 8th MONTH WITHOUT EMPLOYER PROVIDED HEALTH COVERAGE	Part B coverage starts the month after the month requested

In addition to the Medicare premium penalty and the loss of health coverage protection you are entitled to, if you fail to enroll in Medicare, Health Fund benefits will be reduced as if Medicare had paid its portion. (See our on-line Medicare Users Guide Appendix A for examples)

13) **WHAT IF MY DOCTOR DOESN'T TAKE MEDICARE** There are two ways a doctor may elect not to accept Medicare:

Non-participating providers are doctors who don't routinely take Medicare assignment; they don't accept Medicare's discount system, nor will they provide the paperwork Medicare needs to pay on a claim.

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In order for the Health Fund to consider these claims you must submit a copy of the health provider's opt-out letter to the Health Fund. Without this letter, the claim will be denied.

You will be responsible for the full cost of care you received. Since the provider doesn't accept Medicare's assignment, there would be no provider discount amount. The patient is responsible for the amount over Medicare's allowance. You then have to contact the Health Fund and seek reimbursement for the portion the Health Fund would have paid if the provider had been paid by Medicare.

If the provider does not bill Medicare, you will have to bill Medicare. It is only after this Medicare bill has been submitted (by you) that the Health Fund will pay its portion.

Opt-Out Providers are doctors who formally opt-out of the Medicare system. If a doctor elects to go this route, they may not be accepted back into the Medicare system for 24 months. Medicare will not cover this provider's services. If your doctor has opted out, he/she may have you enter into a private contract that requires the patient to pay for the services in full at the time they are provided. The Health Fund does not honor private contracts and the Health Fund will process your claims as if Medicare is involved and estimate Medicare's benefit.

The Health Fund can help you with the complex paperwork required to get some healthcare cost reimbursement when dealing with a doctor who has formally opted out of Medicare.

Non-Participating and Opt-Out providers can make it difficult to ascertain what you should pay.

If you need help with paperwork or managing administrative processes, please call the Health Fund at (818) 846-1015 and we will be glad to assist you.

If your doctor has made the decision to formally opt-out of Medicare you will be liable for higher costs. In this circumstance, it may be worth discussing the physician's Medicare policy, or see if the doctor is willing to make some accommodations. If the doctor is unwilling to work with you, unfortunately a writer has to either accept higher costs or find a physician who does accept Medicare.

No one likes the idea of having to look for a new medical professional, particularly if they have been working with the same medical provider for many years. If the doctor in question is an internist, you may want to elect to stay with the physician and pay the office visit costs. Blood tests, prescriptions and other medical

procedures may well still be covered if they are provided by third parties who have not opted-out.

You will need to be especially careful if you choose to go this route should you be hospitalized, as any visits from your healthcare professional would be substantially more expensive for you than would be the case otherwise.

If you do decide you need a new healthcare provider, there is an enormous population of medical professionals to draw upon. (See APPENDIX E for more information)

If you live in Southern California, you may want to consider using The Industry Health Network. This is a PPO-type narrow network available only to entertainment industry professionals. It has very high quality services and very low copays.

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III. MEDICARE PART A, B, C, AND D

MEDICARE PART A Medicare Part A helps cover inpatient hospitalization, hospice, and home health care costs. To avoid late enrollment penalties, enroll in Medicare Part A (and Part B) during your Initial Enrollment Period when you first become eligible at 65 or, if you are still working after age 65 and have employer-provided coverage, during your Special Enrollment Period.

If you fail to enroll in Medicare Part A within three months of your 65th birthday (unless you qualify for a Special Enrollment Period), you will be liable for uncovered medical costs, and you will also pay a 10% penalty in additional premium payments for every 12-month period that you fail to enroll. You'll have to pay the higher premium for twice the number of years you could have had Part A, but weren't enrolled in the program.

To avoid late enrollment penalties, enroll in Medicare Part A as soon as possible, but no later than three months after the month of your 65th birthday *(unless a Special Enrollment Period applies)*

If you're already getting benefits from Social Security, you'll automatically get Medicare Part A (and Part B) starting the first day of the month you turn 65. (If your birthday is on the first day of the month, Part A (and Part B) will start the first day of the prior month.) You can also request that the Part B premium be paid automatically from your Social Security check.

If you are not receiving Social Security benefits when you turn 65, to avoid late enrollment penalties, you must enroll in Medicare Part A during the 7-month initial enrollment period, which begins three months preceding the month in which your 65th birthday falls, includes the month in which you turn 65, and ends the three months after, unless a Special Enrollment Period applies.

You can apply online if you meet certain requirements. Here is the link to enroll online: https://secure.ssa.gov/iClaim/rib

You can find answers to questions about the online application here: https://www.socialsecurity.gov/medicare/apply.html

MEDICARE PART B This helps cover doctors' services – and many other medical services and supplies that are not covered by Medicare Part A such as

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lab tests, ambulance transportation, second opinions, durable medical equipment like CPAPs, and some preventive services.

If you enroll in Part B late, you will also be liable for uncovered medical costs, and may have to pay a late enrollment penalty for as long as you have Part B coverage. For each 12-month period you delay enrollment in Part B, you will have to pay an extra 10% of the Part B premium, unless you qualify for a Special Enrollment Period.

Make sure you pay your Medicare Part B premium. Simply signing up does not grant coverage.

IF YOU ARE WORKING AT A JOB THAT PROVIDES HEALTH COVERAGE then you do not need to enroll in Part B during your Initial Enrollment Period to avoid late penalties and can wait, if you wish, until your employer-supplied health coverage runs out. You have eight months that begin the month after your employment ends or your employer-supplied health coverage ends (whichever happens first) to enroll in Medicare Part B. (See the chart on page 16 for more details)

IF YOU ARE NOT WORKING AT A JOB THAT PROVIDES HEALTH INSURANCE COVERAGE then to avoid late penalties you need to enroll in Medicare Part B (as well as Medicare Part A) in the 7-month Initial Enrollment Period, which begins three months preceding the month in which your 65th birthday falls, includes the month in which you turn 65, and ends in the three months after.

If you fail to enroll in Medicare Part A in the initial enrollment period (unless you qualify for a Special Enrollment Period), you will be liable for uncovered medical costs, and you will also pay a 10% penalty in additional premium payments for every 12-month period that you fail to enroll. You'll have to pay the higher premium for twice the number of years you could have had Part A, but didn't enroll. If you enroll in Part B late, you will also be liable for uncovered medical costs, and may have to pay a late enrollment penalty for as long as you have Part B coverage. For each 12-month period you delay enrollment in Part B, you will have to pay an extra 10% of the Part B premium, unless you qualify for a Special Enrollment Period. (Please note: Make sure you pay your Part B premium. Merely signing up does not activate coverage.)

If you are not receiving health coverage from employment, then to avoid late penalties you will want to enroll in a timely manner for Medicare Part B.

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APPENDIX D lays out the monthly premium cost for Part B as of November 2015.

MEDICARE PART C Technically, this is called Medicare Advantage, but it is almost universally referred to as Medicare Part C. It works like this: Private companies offer healthcare plans that Medicare approves. If you join a Medicare Advantage Plan, you still have Medicare, but you'll get your Medicare Part A and Medicare Part B coverage through the Medicare Advantage Plan, not Original Medicare.

Most writers elect Medicare Part C only if they are not covered as a Certified Retiree. You may want to consider whether Part C is right for you based on your needs.

Medicare Advantage might place you in an HMO like Kaiser, or in an open-access or gatekeeper plan such as are typically offered by large health carriers like Blue Cross. If the cost-certainty of such a situation appeals to you despite the other restrictions you are likely to encounter, then this might be an option you would select.

MEDICARE PART D This is Medicare's drug coverage program. The Health Fund has what Medicare refers to as "creditable" drug coverage. What this means is that the Health Fund has determined that its prescription drug coverage is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. If you decide to keep Fund coverage and not opt for Medicare Part D when you are first eligible, you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you decide to opt for Medicare Part D, your Fund drug coverage is suspended until such time as you no longer have Medicare Part D coverage.

If you are a Certified Retiree, one reason it might make sense for you to purchase Medicare Part D is if Medicare's formulary carries a drug you need that the Health Fund does not and the cost of that drug is prohibitive.

If you are not a Certified Retiree and are not on Earned Coverage, you may want to consider signing up for Medicare Part D to cover your prescription needs.

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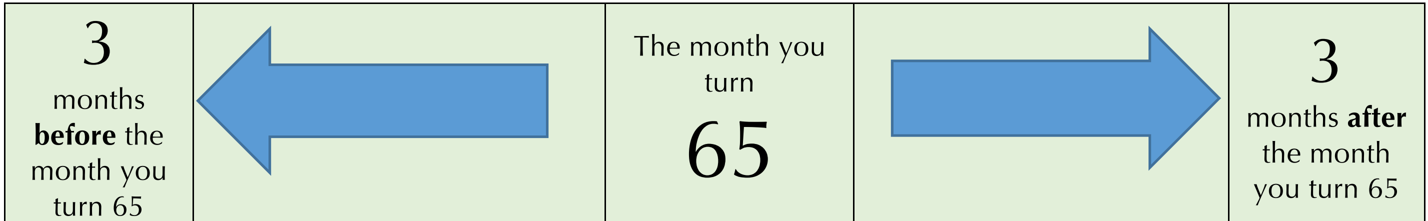
IV. MEDICARE INITIAL ENROLLMENT



In the Initial Enrollment Period, you have seven months to enroll in Medicare – three months before the month of your birthday, the month of your birthday, and until three months after the month of your birthday.

If you enroll in the month you turn 65 or AFTER your 65th birthday, health coverage begins on the first day of the month you enrolled – there is no retroactive coverage. For example, if you enroll in the third month after your birthday, your coverage starts that month. Any medical bills incurred in the month(s) before then would not be covered by Medicare even though you would have been entitled to coverage if you'd enrolled earlier.*

If you miss the initial Medicare Part A (if you have to buy it) and/or Part B (for which you must pay premiums) enrollment period, you will have to wait until the next General Enrollment Period (January 1- March 31 each year) to enroll, unless you are eligible for a Special Enrollment Period. If you enroll during the General Enrollment Period, your coverage won't start until July 1 of that year. Any medical costs incurred during this waiting period will not be covered by Medicare and any Fund benefits will be reduced as if Medicare had paid its portion and you will be responsible for the difference.

If you fail to enroll in Medicare Part A during the Initial Enrollment Period (unless you qualify for a Special Enrollment Period), you will be liable for uncovered medical costs, and you will also pay a 10% penalty in additional premium payments for every 12-month period that you fail to enroll. You'll have to pay the higher premium for twice the number of years you could have had Part A, but didn't enroll. If you enroll in Part B late, you will also be liable for uncovered medical costs, and may have to pay a late enrollment penalty for as long as you have Part B coverage. For each 12-month period you delay enrollment in Part B, you will have to pay an extra 10% of the Part B premium, unless you qualify for a Special Enrollment Period.*

* In addition to the Medicare premium penalty and the loss of direct health coverage protection you are entitled to, if you fail to enroll in Medicare, Fund benefits will be reduced as if Medicare had paid its portion and you will be responsible for the difference – this can be very costly. (For more details, see Appendix A.)

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V. HOW MEDICARE WORKS IF YOU GO BACK AND FORTH BETWEEN WORKING AND UNEMPLOYMENT

If you are already working – or you just went back to work – while you may want to enroll in Medicare Part A, you will not need to enroll in Medicare Part B at that time to avoid any late enrollment penalties. You have a Special Enrollment Period of eight months that begins the month after your employment ends or you are no longer receiving health insurance from your employer (whichever happens first) to enroll.

To avoid late enrollment penalties, make sure you apply and pay for Medicare Part B during your Special Enrollment Period. If you fail to make a payment during the allotted eight-month time frame, it will be the same as if you had never enrolled. You will have to wait until the following year during the General Enrollment Period to enroll, and you will incur a permanent 10% premium penalty for every year you delay.

In addition to the Medicare premium penalty and the loss of health coverage protection you are entitled to, if you fail to enroll in Medicare, Fund benefits will be reduced as if Medicare had paid its portion. (See the charts on page 7 or Appendix A for examples)

When you lose health coverage after 65, Medicare treats the time period(s) in which you apply for Medicare Part B differently depending upon how soon you apply. It works like this:

TIME PERIOD IN WHICH MEDICARE PART B IS REQUESTED	MONTH COVERAGE BEGINS
1st THREE MONTHS WITHOUT EMPLOYER PROVIDED HEALTH COVERAGE	Part B coverage starts the same month it is requested.
4th THROUGH 8th MONTH WITHOUT EMPLOYER PROVIDED HEALTH COVERAGE	Part B coverage starts the month after the month requested

SUPPOSE YOU WENT ONE YEAR WITHOUT SIGNING UP*: Your Medicare Part B premium would be $115.39 a month instead of $104.90. It would cost you an extra $125.88 a year than if you had filed inside the eligibility window. If you live an additional 20 years, you will pay an additional $2,517.60 than otherwise would have been necessary. This additional premium increases each year you fail to enroll.

As you can see, it is extremely important to enroll and pay for Medicare Part B in a timely manner. If you're already receiving Social Security then you can have the premium automatically deducted from your check, but if you are not, you will have to make arrangements to send in your premium. Without timely payment, you will be subject to the increased costs detailed above.

* This example is for illustrative purposes only and may not reflect the actual Medicare Part B premium or any late enrollment payment you may have to pay.

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VI. HOW IT WORKS WHEN YOU FILE A CLAIM FOR HEALTHCARE SERVICES UNDER MEDICARE AND YOU ALSO HAVE FUND COVERAGE

IF THE HEALTH FUND IS PRIMARY AND MEDICARE IS SECONDARY In this circumstance you have your traditional Fund coverage and Medicare will for the most part save you only a few dollars here and there. For all intents and purposes there is little or no difference in what you will pay for healthcare.

IF MEDICARE IS PRIMARY AND THE HEALTH FUND IS SECONDARY When Medicare is primary and Fund coverage is secondary, major medical issues will cost you pretty much the same – or even a little less than if you had the Health Fund coverage alone. (See the charts on page 9 or Appendix B for some typical examples)

If you see a lot of doctors but rarely have medical issues which require hospitalization, then Medicare may end up costing you slightly more than if the Health Fund was your primary provider. (See Appendix C for details)

SPOUSES' HEALTH PLANS AND HOW THEY MAY AFFECT YOUR COVERAGE

IF YOUR SPOUSE IS WORKING AND THE SPOUSE'S EMPLOYER IS PROVIDING HEALTH COVERAGE that covers you, then the spouse's plan will become the primary carrier, Medicare will become the secondary carrier, and the Health Fund will be in third position (assuming you are a Certified Retiree).

IF YOUR SPOUSE IS WORKING AND YOU ARE ALSO WORKING, then your employer-provided coverage will be primary for your claims, your spouse's coverage will be second, and Medicare will be third.

IF YOU AND YOUR SPOUSE ARE BOTH RETIRED AND GETTING RETIREE HEALTH COVERAGE FROM SEPARATE FUNDS, then Medicare would be your

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primary health coverage carrier, the Health Fund would be second, and your spouse's would be third.

COB (COORDINATION OF BENEFITS) One of the first questions writers ask is, "How does this all fit together and who do I turn to if there is a payment issue, Medicare or the Health Fund?" If there's a problem, come to us, we'll help you work through the process, and if necessary, we'll assist you in dealing with Medicare.

The Health Fund coordinates your benefits with Medicare so that the combined medical payments of Medicare and the Health Fund are equal to – but not more than – what the Health Fund would have paid if Medicare were not involved.

ANNUAL DEDUCTIBLE AND OUT OF POCKET (OOP) COSTS The Health Fund has a $300 annual deductible, regardless of whether you are receiving services in-network or out of network. If you're getting medical care from a provider in-network, the Health Fund covers 85% of the costs until you reach the $1,000 out-of-pocket annual maximum and then it covers 100% of costs.

If your medical care is coming from a doctor out-of-network, you still have an annual deductible of $300, and then the Health Fund pays 70% of costs until you reach the $2,500 out-of-pocket annual maximum after which the Health Fund cover 100% of costs.

IF YOUR SPOUSE IS WORKING AND RECEIVING HEALTH COVERAGE The Health Fund would be the secondary carrier if you and your spouse were both working and receiving health coverage.

If your spouse is working and you are a Certified Retiree, then your spouse's plan would be primary, Medicare would be secondary, and the Health Fund would be third.

WHEN THE HEALTH FUND PLAN IS SECONDARY The Health Fund coordinates your benefits with Medicare so that the combined medical payments of Medicare and the Health Fund are equal to but not more than what the Health Fund would have paid if Medicare were not involved.

The same is true if your spouse's plan is the primary carrier.

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IF MEDICARE'S BENEFIT IS GREATER THAN THE HEALTH FUND The Health Fund pays nothing toward the claim in this circumstance. Once a writer has met the annual deductible and the OOP obligations, the writer usually won't be paying any more than he/she would have if the Health Fund were the sole provider and in some cases he/she will actually pay less:

Physician Services only (non-PPO Provider, deductible and OOP not met)

Certified Retiree Medicare COB Calculation and Active Coverage Comparison	Certified Retiree	Active Coverage
Provider's Billed Amount	$305.00	$305.00
Medicare/Fund's Allowed Amount	$198.66	$271.00
Deductible met this claim (maximum of $300)	$10.00	$10.00
Applied to Out-of-Pocket (30% of Allowed Amount after deductible, max of $2,500)	$56.60	$78.30
Fund's Normal Liability using Medicare's Allowed Amount	$132.06	$182.70
Less: Medicare's payment	$158.93	$0.00
Fund's payment to the provider	**$0.00**	**$182.70**
Participant's payment to the provider	**$39.73**	**$122.30**

THINGS THE HEALTH FUND COVERS MEDICARE DOESN'T There is an additional benefit to Fund coverage in that the Health Fund covers services like acupuncture that Medicare does not, and often offers more generous numbers of appointments for things like physical therapy sessions. The Health Fund will coordinate with Medicare by taking into consideration Medicare's allowable amount, and pay the difference up to the amount the Health Fund would normally pay.

For Fund-eligible services not covered by Medicare, such as acupuncture services, vision, prescriptions, and dental, the Health Fund will act as primary carrier.

OTHER CONSIDERATIONS If there is a hospital stay, the OOP minimums are generally easily met, but if you see doctor(s) several times a year, you will find that between Medicare and the Health Fund, your final out-of-pocket expenses may not exceed $1,300 (for 2015) for in-network providers and $2,800 (for 2015) for out-of-network providers. It is worth noting that most labs and anesthesiologists are out of network.

There is an additional expense incurred when Medicare is the pri-

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mary health insurance carrier because there is a monthly premium for Medicare Part B, usually in the amount of $104.90 per month ($1,258.80 annually). See APPENDIX D for more details.

Having Medicare as your primary health care provider generally costs an additional $1,258.80 annually. To help offset some of this cost, when you turn 65, the Health Fund waives the dependent premium ($600 a year). Thus, if Medicare is your primary healthcare coverage provider, and you have dependents, you are generally looking at an additional $658.80 annually, rather than $1,258.80. If you don't have a dependent(s), It's worth noting that the Health Fund covers several potentially expensive services that Medicare does not: dental, vision, and prescription costs – as well as wellness care for both Earned Coverage participants as well as Certified Retirees.

MEDICARE ASSIGNMENT

DOES YOUR DOCTOR ACCEPT MEDICARE? There are three possible answers to the question of whether or not a doctor accepts Medicare, and each of these has a vastly different consequence to you:

YES, MY DOCTOR DOES ACCEPT MEDICARE. This is the simplest outcome: The provider accepts Medicare's approved amount and discounts the remaining amount. You have the normal annual deductible, OOP, COB, and you're done.

NO, MY DOCTOR DOESN'T ACCEPT MEDICARE. There are two ways a doctor may elect not to accept Medicare:

Non-participating providers are doctors who don't routinely take Medicare assignment; they don't accept Medicare's discount system, nor will they provide the paperwork Medicare needs to pay on a claim.

You will be responsible for the full cost of care you received. Since the provider doesn't accept Medicare's assignment, there would be no provider discount amount. The patient is responsible for the amount over

Non-Participating and Opt-Out providers can make it difficult to ascertain what you should pay.

If you need help with paperwork or managing administrative processes, please call the Health Fund at (818) 846-1015 and we will be glad to assist you.

In order for the Health Fund to consider these claims you must submit a copy of the health provider's opt-out letter to the Health Fund. Without this letter, the claim will be denied.

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Medicare's allowance. You then have to contact the Health Fund and seek reimbursement for the portion the Health Fund would have paid if the provider had been paid by Medicare.

If the provider does not bill Medicare, you will have to bill Medicare. It is only after this Medicare bill has been submitted (by you) that the Health Fund will pay its portion.

Opt-Out Providers are doctors who formally opt-out of the Medicare system. If a doctor elects to go this route, they may not be accepted back into the Medicare system for 24 months. Medicare will not cover this provider's services. If your doctor has opted out, he/she may have you enter into a private contract that requires the patient to pay for the services in full at the time they are provided. The Health Fund does not honor private contracts and the Health Fund will process your claims as if Medicare is involved and estimate Medicare's benefit.

If your doctor has made the decision to formally opt-out of Medicare you will be liable for higher costs. In this circumstance, it may be worth discussing the physician's Medicare policy, or see if the doctor is willing to make some accommodations. If the doctor is unwilling to work with you, unfortunately a writer has to either accept higher costs or find a physician who does accept Medicare.

No one likes the idea of having to look for a new medical professional, particularly if they have been working with the same medical provider for many years. If the doctor in question is an internist, you may want to elect to stay with the physician and pay the office visit costs. Blood tests, prescriptions and other medical procedures may well still be covered if they are provided by third parties who have not opted-out.

The Health Fund can help you with the complex paperwork required to get some healthcare cost reimbursement when dealing with a doctor who has formally opted out of Medicare.

You will need to be especially careful if you choose to go this route should you be hospitalized, as any visits from your healthcare professional would be substantially more expensive for you than would be the case otherwise.

If you do decide you need a new healthcare provider, there is an enormous population of medical professionals to draw upon. (See APPENDIX E for more information)

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If you live in Southern California, you may want to consider using The Industry Health Network. This is a PPO-type narrow network available only to entertainment industry professionals. It has very high quality services and very low co-pays.

SUMMING UP

We hope you now better understand how Medicare works and how it affects your Fund coverage.

In the future, we will be holding seminars to help you learn more about Medicare. We will place a notice on the web site in advance of the event.

You can get more information at the PWGA web site: www.wgaplans.org or at Medicare's own web site: www.medicare.gov.

Finally, please keep in mind, our staff is here to help you with any questions or concerns you might have: (818) 846-1015.

##

This summary is intended to provide general information about enrolling in Medicare and the impact enrollment in Medicare may have on some of your health coverage options offered by the Health Fund. This summary is not a legal document and is not intended to be, nor should it be relied upon as, an exhaustive discussion of Medicare, the Medicare enrollment requirements, or benefits offered by the Health Fund. These rules may also change over time. Since this document is not exhaustive and does not take into account your personal circumstances, we strongly encourage you to personally review the Medicare enrollment requirements and consult with your personal advisors before making any decisions related to Social Security benefits and Medicare enrollment. Complete descriptions of the benefits offered by the Health Fund can be found in the applicable legal plan documents. If there is a conflict between the material in this document and the legal plan documents, the legal plan documents govern. Please also keep in mind that the Board of Trustees of the Health Fund reserves the right to amend, modify or terminate at any time and without advance notice any and all terms of the Health Fund's plan of benefits, including, without limitation, Certified Retiree health benefits and the eligibility requirements for those benefits, both for actives and for those who are inactive or already retired.

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APPENDIX A

EXAMPLE 1

Example 1: Multiple Claims - WGIHF's Allowed Amount is Greater than Medicare (deductible met)

Medicare is Primary, WGIHF is Secondary - COB	Comparison of Participant Enrolled In Vs. Not Enrolled In Medicare		WGIHF is Secondary - Medicare Estimate 80%
	Certified Retiree (≥ 65) Enrolled In Medicare	Certified Retiree (≥ 65) Not Enrolled In Medicare	
Provider's Billed Amount	$1,500.00	$1,500.00	Provider's Billed Amount
Medicare's Allowed Amount	$800.00	$1,000.00	Fund's Allowed Amount (based on Blue Cross contract)
Applied to Out-of-Pocket (15% of Medicare's Allowed Amount, maximum of $1,000)	$120.00	$150.00	Applied to Out-of-Pocket (15% of Fund's Allowed Amount, maximum of $1,000)
Fund's Normal Liability using Medicare's Allowed Amount (allowed amount less OOP)	$680.00	$850.00	Fund's Normal Liability using Fund's Allowed Amount (allowed amount less OOP)
Less: Medicare's payment	$640.00	$800.00	Less: Medicare Estimated Payment (80% of Fund's Allowed Amount)
Fund's payment to the provider	**$40.00**	**$50.00**	**Fund's payment to the provider**
Participant's payment to the provider	**$120.00**	**$950.00**	**Participant's payment to the provider (includes Medicare estimated 80% of Fund's Allowed Amount)**

In this example, the writer's failure to enroll in Medicare cost the writer an extra $830.

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APPENDIX A
EXAMPLE 2

Example 2: Single Claim - WGIHF's Allowed Amount is Greater than Medicare (deductible met)

Medicare is Primary, WGIHF is Secondary - COB	Comparison of Participant Enrolled In Vs. Not Enrolled In Medicare		WGIHF is Secondary - Medicare Estimate 80%
	Certified Retiree (≥ 65) Enrolled In Medicare	Certified Retiree (≥ 65) Not Enrolled In Medicare	
Provider's Billed Amount	$76,593.50	$76,593.50	Provider's Billed Amount
Medicare's Allowed Amount	$1,096.70	$35,283.30	Fund's Allowed Amount (based on Blue Cross contract)
Applied to Out-of-Pocket (15% of Medicare's Allowed Amount, maximum of $1,000)	$164.51	$1,000.00	Applied to Out-of-Pocket (15% of Fund's Allowed Amount, maximum of $1,000)
Fund's Normal Liability using Medicare's Allowed Amount (allowed amount less OOP)	$932.20	$34,283.30	Fund's Normal Liability using Fund's Allowed Amount (allowed amount less OOP)
Less: Medicare's payment	$873.80	$28,226.64	Less: Medicare Estimated Payment (80% of Fund's Allowed Amount)
Fund's payment to the provider	**$58.40**	**$6,056.66**	**Fund's payment to the provider**
Participant's payment to the provider	**$164.51**	**$29,226.64**	**Participant's payment to the provider (includes Medicare estimated 80% of Fund's Allowed Amount)**

In this example, the writer's failure to enroll in Medicare cost the writer an additional $29,062.14.

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APPENDIX A

EXAMPLE 3

Example 3: Single Claim (deductible and OOP met)

Medicare is Primary, WGIHF is Secondary - COB	Comparison of Participant Enrolled In Vs. Not Enrolled In Medicare		WGIHF is Secondary - Medicare Estimate 80%
	Certified Retiree (≥ 65) Enrolled In Medicare	Certified Retiree (≥ 65) Not Enrolled In Medicare	
Provider's Billed Amount	$7,329.30	$7,329.30	Provider's Billed Amount
Medicare's Allowed Amount	**$1,729.69**	**$3,290.53**	Fund's Allowed Amount (based on Blue Cross contract)
Applied to Out-of-Pocket ($1,000 OOP met)	$0.00	$0.00	Applied to Out-of-Pocket ($1,000 OOP met)
Fund's Normal Liability using Medicare's Allowed Amount (allowed amount less OOP)	**$1,729.69**	**$3,290.53**	Fund's Normal Liability using Fund's Allowed Amount (allowed amount less OOP)
Less: Medicare's payment	$1,378.13	$2,632.42	Less: Medicare Estimated Payment (80% of Fund's Allowed Amount)
Fund's payment to the provider	**$351.56**	**$658.11**	**Fund's payment to the provider**
Participant's payment to the provider	**$0.00**	**$2,632.42**	**Participant's payment to the provider (includes Medicare estimated 80% of Fund's Allowed Amount)**

In this example, the writer's failure to enroll in Medicare cost the writer an additional $2,632.42.

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APPENDIX B

EXAMPLE 1

Example 1: Hospital Claim - 20-day admission, PPO Provider (deductible met)

Medicare is Primary, WGIHF is Secondary - COB	Comparison of Participant Active Earned Vs Certified Retiree		Writers' Guild-Industry Health Fund (WGIHF) is Primary No COB
	Certified Retiree Participant ≥ 65 Years of Age	Active Earned Participant ≤ 64 Years of Age	
Provider's Billed Amount	$125,133.89	$125,133.89	Provider's Billed Amount
Medicare's Allowed Amount	$9,829.65	$115,304.24	Fund's Allowed Amount
Patient's $100 copay per admission	$100.00	$100.00	Patient's $100 copay per admission
Applied to Out-of-Pocket (15% of Medicare's Allowed Amount, maximum of $1,000)	$1,000.00	$1,000.00	Applied to Out-of-Pocket (15% of Fund's Allowed Amount, maximum of $1,000)
Fund’s Normal Liability using Medicare's Allowed Amount (allowed amount less copay and OOP)	$8,729.65	$114,204.24	Fund’s Normal Liability using Fund's Allowed Amount (allowed amount less copay and OOP)
	$1,100.00	**$1,100.00**	

In this example, there would have been no difference in cost to the writer when Medicare is the primary healthcare provider.

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APPENDIX B

EXAMPLE 2

Example 2: Annual claims profile (includes Inpatient Hospital Services, deductible and OOP met)

Medicare is Primary, WGIHF is Secondary - COB	Comparison of Participant Active Earned Vs Certified Retiree		Writers' Guild-Industry Health Fund (WGIHF) is Primary No COB
	Certified Retiree Participant ≥ 65 Years of Age	Active Earned Participant ≤ 64 Years of Age	
Provider's Billed Amount	$125,133.89	$125,133.89	Provider's Billed Amount
Medicare's Allowed Amount	$9,829.65	$115,304.24	Fund's Allowed Amount (based on Blue Cross contract)
Patient's $100 copay per admission	$100.00	$100.00	Patient's $100 copay per admission
Applied to Out-of-Pocket ($1,000 OOP met)	$0.00	$0.00	Applied to Out-of-Pocket ($1,000 OOP met)
Fund's Normal Liability using Medicare's Allowed Amount	$9,729.65	$115,204.24	Fund's Normal Liability using Fund's Allowed Amount (allowed amount less copay and OOP)
Less: Medicare's payment (Medicare's Allowed Amount less 1st 60 days patient coinsurance of $1,184)	$8,645.65	N/A	
Fund's payment to the provider	**$1,084.00**	**$115,404.24**	**Fund's payment to the provider**
Participant's payment to the provider	**$100.00**	**$100.00**	**Participant's payment to the provider (copay)**

*Note: For Medicare claims, the Health Fund allows Medicare's allowance over Anthem Blue Cross

In this example, there is no cost difference between Medicare and WGA coverage.

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APPENDIX B

EXAMPLE 3

Example 3: Physician Services only - PPO Provider (deductible and OOP not met)

Medicare is Primary, WGIHF is Secondary - COB	Comparison of Participant Active Earned Vs Certified Retiree		Writers' Guild-Industry Health Fund (WGIHF) is Primary No COB
	Certified Retiree Participant ≥ 65 Years of Age	Active Earned Participant ≤ 64 Years of Age	
Provider's Billed Amount	$305.00	$305.00	Provider's Billed Amount
Medicare's Allowed Amount	$198.66	$106.34	Fund's Allowed Amount (based on Blue Cross contract)
Deductible met this claim (maximum of $300)	$10.00	$10.00	Deductible met this claim (maximum of $300)
Applied to Out-of-Pocket (15% of Medicare's Allowed Amount, maximum of $1,000)	$28.30	$14.45	Applied to Out-of-Pocket (15% of Medicare's Allowed Amount, maximum of $1,000)
Fund's Normal Liability using Medicare's Allowed Amount	$160.36	$81.89	Fund's Normal Liability using Fund's Allowed Amount (allowed amount less copay and OOP)
Less: Medicare's payment	$158.93	N/A	
Fund's payment to the provider	**$1.43**	**$81.89**	**Fund's payment to the provider**
Participant's payment to the provider	**$38.30**	**$24.45**	**Participant's payment to the provider**

*Note: For Medicare claims, the Health Fund allows Medicare's allowance over Anthem Blue Cross (Medicare's allowance greater than the Health Fund on the above example)

In this example, the writer pays $13.85 more because Medicare is the primary provider than would have been the case if the WGA was the primary provider.

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APPENDIX B

EXAMPLE 4

Example 4: Physician Services, PPO Provider
(deductible & OOP Met)

Medicare is Primary, WGIHF is Secondary - COB	Comparison of Participant Active Earned Vs Certified Retiree		Writers' Guild-Industry Health Fund (WGIHF) is Primary No COB
	Certified Retiree Participant ≥ 65 Years of Age	Active Earned Participant ≤ 64 Years of Age	
Provider's Billed Amount	$305.00	$305.00	Provider's Billed Amount
Medicare's Allowed Amount	$198.66	$106.34	Fund's Allowed Amount (based on Blue Cross contract)
Applied to Out-of-Pocket ($1,000 OOP met)	$0.00	$0.00	Applied to Out-of-Pocket ($1,000 OOP met)
Fund's Normal Liability using Medicare's Allowed Amount	$198.66	$106.34	Fund's Normal Liability using Fund's Allowed Amount
Less Medicare's payment	$158.93	N/A	
Fund's payment to the provider	**$39.73**	**$106.34**	**Fund's payment to the provider**
Participant's payment to the provider	**$0.00**	**$0.00**	**Participant's payment to the provider**

*Note: For Medicare claims, the Health Fund allows Medicare's allowance over Anthem Blue Cross (Medicare's allowance greater than the Health Fund on the above example)

In this example there is no difference between the cost to the writer whether the WGA is the primary provider or Medicare is in the first position.

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APPENDIX C

(WGA primary vs Medicare primary – cost to writer)

Earned versus Retiree Coverage

Comparison of Benefits and COB Rules

Health Coverage – Premium and COB Earned Coverage – No Medicare	Health Coverage – Premium and COB Certified Retiree - Medicare Coverage
Premium: Individual Premium: $ 0.00 Dependent Premium: $150 per quarter ($600 annually) Medicare Government Tax withholding: 2.9% of annual salary. 1.45% is paid by the employer and 1.45% is paid by the writer. All 2.9% is paid by the writer if there is a loan out company.	**Premium:** WGA Individual Premium: $ 0.00 WGA Dependent Premium: $150.00 per quarter (if age 65 or older, and on retiree coverage, the premium is waived) Medicare Part B Premium: $104.90 per month ($1,258.80 annually)
COB Rule: Usually, the plan covering someone as a participant based on employment is the primary plan and the plan covering someone as a dependent is the secondary plan. For dependent children covered under more than one plan – the birthday rule is applied. The plan of the parent whose birthday is earliest (month & day) in the year is the primary plan. If both parents have the same birthday, the primary plan is the one that has covered the parent longer. Please refer to the SPD for "Other COB Rules". The Plan remains the primary coverage over Medicare if the participant is age 65 and over.	**COB Rule:** Medicare coverage will be the primary plan when the Certified Retiree turns age 65. If the Certified Retiree has coverage through another plan based on employment or covered as a dependent, the standard coordination of benefits determination for the secondary or tertiary will be made. See the SPD for the COB determination rules.
Medicare COB Approach: None – The Plan is the primary coverage and Medicare is secondary.	**Medicare COB Approach:** **Carve Out or non-duplication approach –** Under this method, when the Health Fund is the secondary plan, the primary plan's benefit is subtracted from the Health Fund's normal benefit, and the difference, if any, is paid on the claim. If the primary plan's benefit is greater than or equal to the Health Fund's benefit on a claim, nothing is paid by the Health Fund. If the primary plan's benefit is less than the Health Fund's benefit, the difference between the two benefits is paid. With this method, the plan participant continues to be responsible for normal out-of-pocket expenses like deductibles and coinsurance. (see attached examples)

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APPENDIX C

Comparison of Benefits and COB Rules (Cont'd)

Health Coverage Earned Coverage – No Medicare	Health Coverage Certified Retiree - Medicare Coverage
Hospital Coverage – WGA Coverage -Inpatient Care in hospital -Inpatient Care in a skilled nursing facility *Subject to the Plan's hospital $100 copay, then the Plan's Plan's $300 deductible, payable at 85% INN (in Network) or 70% OON (Out Of Network) until the out-of-pocket maximum is met ($1000 INN or $2500 OON), then payable at 100%, no lifetime maximum* -Hospice care services -Home health care services *Subject to the Plan's $300 deductible, payable at 85% INN or 70% OON until the out-of-pocket maximum is met (($1000 INN or $2500 OON), then payable at 100%, no lifetime maximum*	**Hospital Coverage – Medicare Part A** -Inpatient Care in hospital *The patient pays $1184 for the first 60 days, $296 for days 61-90, $592 after 90 days (up to 60 days after your lifetime maximum)* -Inpatient Care in a skilled nursing facility *The patient pays $148 per day for days 21 – 100 days (benefit period)* -Hospice care services – 100% if medically necessary *The patient pays $5 per outpatient prescription for pain and symptom management* -Home health care services – 100% if medically necessary *The patient pays 20% of the Medicare approved amount for durable medical equipment.*
All other services **-**Physician Services -Hospital Outpatient lab and physicians services *Subject to the Plan's $300 deductible, payable at 85% INN or 70% OON until the out-of-pocket maximum is met (($1000 INN or $2500 OON), then payable at 100%, no lifetime maximum*	**All other services – Medicare Part B** **-**Physician Services -Hospital Outpatient lab and physicians' services *Subject to Medicare's Part B deductible of $147, then payable at 80%. No out-of-pocket maximum.*

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APPENDIX D

MEDICARE PART B COSTS*

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Part B income-related monthly adjustment amount	Total monthly Part B premium amount
Less than or equal to $85,000	Less than or equal to $170,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$42.00	$146.90
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$104.90	$209.80
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$167.80	$272.70
Greater than $214,000	Greater than $428,000	$230.80	$335.70

Monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate return, are as follows:

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Part B income-related monthly adjustment amount	Total monthly Part B premium amount
Less than or equal to $85,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $129,000	$167.80	$272.70
Greater than $129,000	$230.80	$335.70

*(All income levels are based on adjusted gross income)

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APPENDIX E

Medicare Providers Available in the Top Participant Geographic areas

Zip Code	**# of Providers with 25 miles (that accept Medicare Assignment)** **Specialty & Count**	**# of Providers with 25 Miles (that accept Medicare Assignment)** **Specialty & Count**	**# of providers within 25 miles (that accept Medicare Assignment)** **Specialty & Count**	
	Family Practice, General Medicine, Geriatrics, Internal Medicine	**Hematology/Oncology**	**Cardiology**	**Number of Opt. Out Providers**
Los Angeles **90025**	4,741	62	531	615
San Francisco **94112**	2,503	66	190	2658
New York **10013**	8,250	494	1,435	3286

Note: In-network Medicare Provider counts obtained from www.Medicare.gov and Number of Opted Out Medicare Providers count was obtained from a Healthcare Payer list.

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