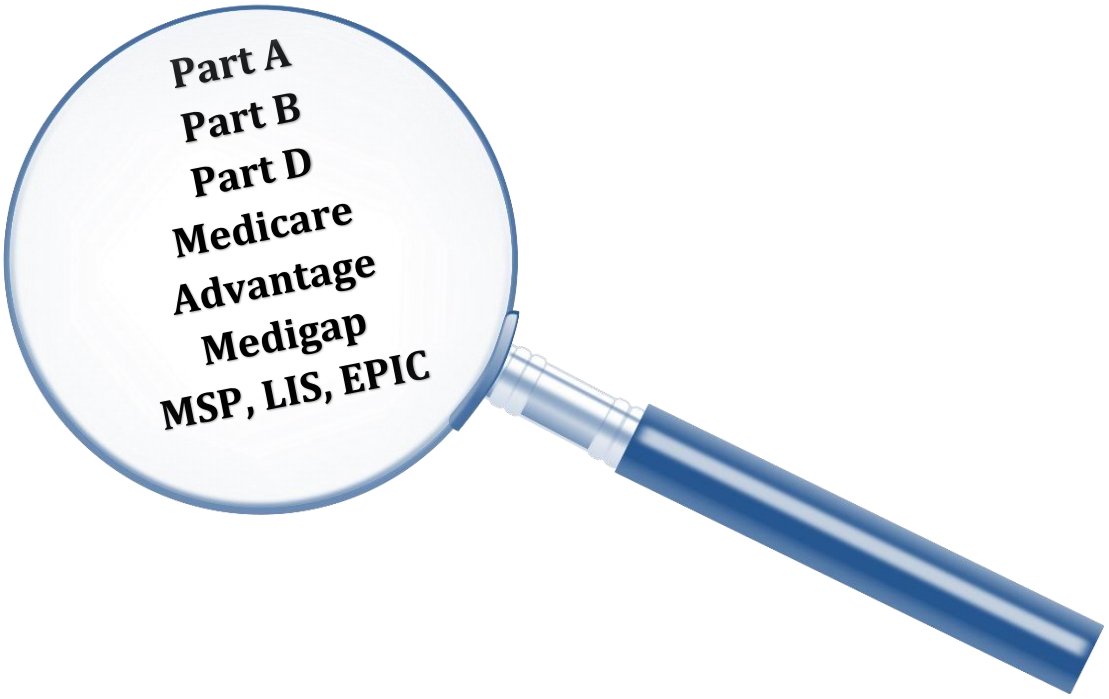
A Closer Look at Medicare and Related Benefits for New Yorkers

2022



Updated March 2022

Department for the Aging

NEW YORK STATE OF OPPORTUNITY. HIICAP Health Insurance Information, Counseling and Assistance Program

Medicare questions? Call Aging Connect at 212-244-6469

ACL Administration for Community Living

SHIP State Health Insurance Assistance Program

Disclaimer:

This information is provided by the New York City Department for Aging and is not to be widely distributed for private-business purposes

This guide has been developed by the New York City Department for the Aging's Health Insurance Information, Counseling and Assistance Program (HIICAP) to help older New Yorkers better understand the health care coverage options currently available in New York City. The topics include Medicare Parts A and B, "Medigap" insurance, Medicare Advantage health plans, Medicare Part D, Medicare Savings Programs, and Medicaid. The information detailed here is current as of the time of printing. Use it in good health!

HIICAP is New York's source for free, current, and impartial information about health care coverage for older people. The HIICAP Helpline can assist you in getting your questions answered. Please call the Department for the Aging's Aging Connect line at 212-AGING-NYC (212-244-6469) and ask for HIICAP to speak with one of our trained counselors.

We have HIICAP counselors available to speak with you over the phone or meet with you in person at one of our counseling sites. Simply call our helpline for a referral to the counselor nearest you.

Please note that inclusion of specific health care benefit programs does not constitute endorsement of these programs on the part of the New York City Department for the Aging.

www.nyc.gov/aging

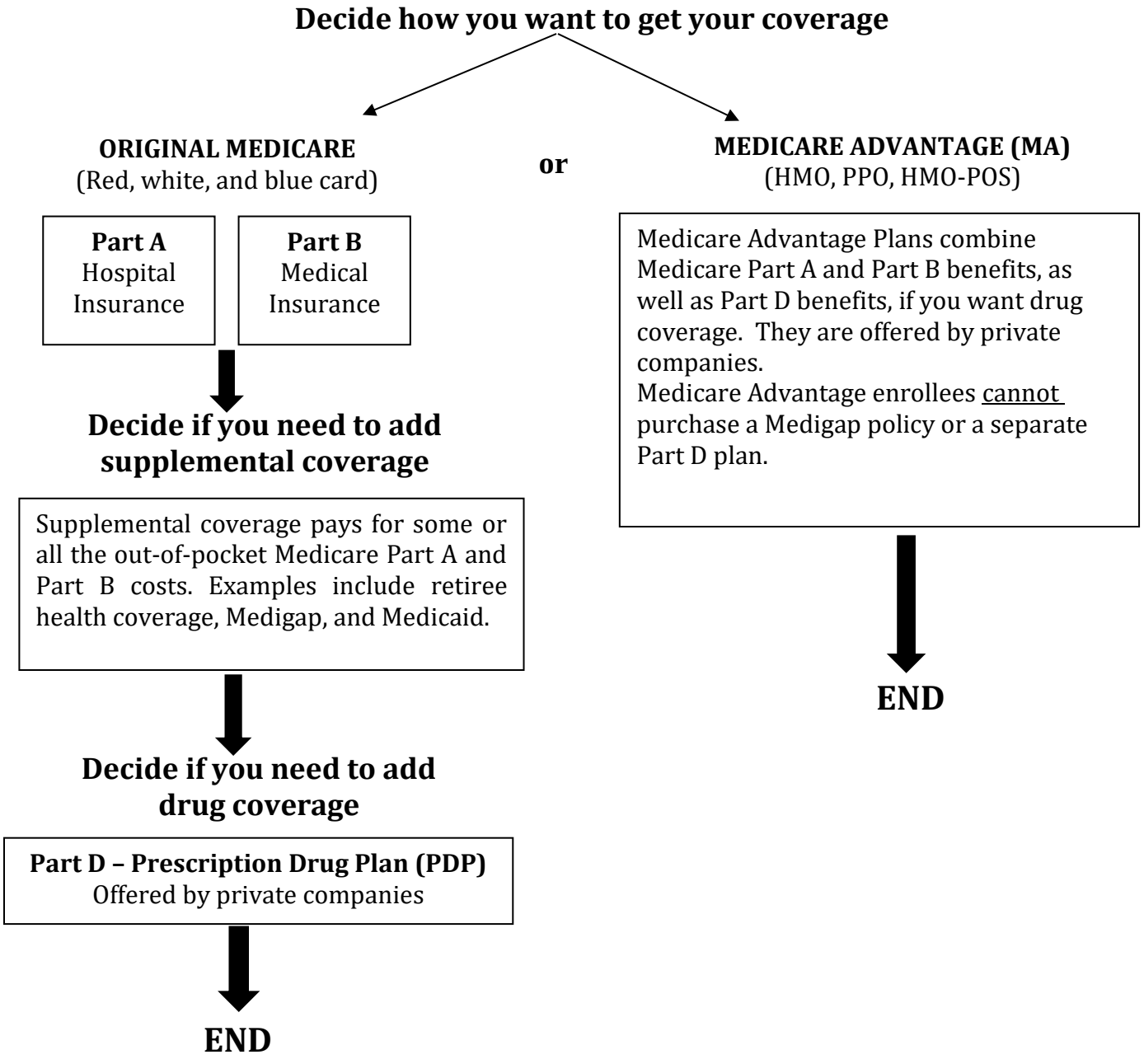
This project was supported, in part, by grant number 90SAPG0033 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

Table of Contents

MEDICARE COVERAGE CHOICES

All Medicare beneficiaries have choices in how they get their Medicare coverage.

There are two main ways to get your coverage: Original Medicare and a Medicare Advantage Plan. Below is a decision tree to help guide your decision making.



MEDICARE

Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people and people with kidney failure (End Stage Renal Disease, ESRD).

The main components to Medicare are:

- Part A - Hospital Insurance
- Part B - Medical Insurance
- Part D - Prescription Drug Coverage

Medicare beneficiaries can choose to get their Medicare benefits through Original Medicare, or from a Medicare Advantage Plan, sometimes referred to as Part C. Medicare Advantage plans are administered by private companies and provide all Medicare Part A and Part B benefits, as well as Part D drug coverage, through managed care. Those enrolling in a Medicare Advantage plan, will have Medicare coverage through that private plan, not through "Original Medicare." See page 4 for a chart summarizing these choices.

Who Is Eligible for Medicare?

- Age: You are eligible for Medicare if you are 65 years old or older and either
  - A U.S. citizen or
  - Legal permanent resident (for at least five consecutive years if not eligible for Social Security).
- People under age 65 can qualify for Medicare
  - After receiving Social Security Disability Insurance (SSDI) for 24 months. Individuals with Amyotrophic Lateral Sclerosis (ALS) qualify the first month they receive SSDI.
  - If they have end stage renal disease (ESRD) and receive continuing dialysis for permanent kidney failure or had a kidney transplant.

How Eligibility Differs for Part A vs. Part B

- To qualify for premium-free Part A at 65, you or your spouse must be insured through Social Security (by having earned 40 quarters (credits) of coverage). Without 40 quarters of coverage, you may still get Medicare by paying a premium for Part A at age 65.
- You do not need 40 quarters of coverage to qualify for Part B; you need to only be either a U.S. Citizen or a legal permanent resident for five (5) consecutive years.

If you have questions about your eligibility for Medicare, or if you want to apply for Medicare, call the Social Security Administration at 1-800-772-1213 (1-800-325-0778 TTY). You can learn more and apply for Medicare at www.socialsecurity.gov.

How Do I Enroll in Medicare?

Some people are automatically enrolled in Medicare, while others need to be proactive. It is important to understand enrollment rules for Part A and Part B in order to avoid a Late Enrollment Penalty (LEP) and/or a gap in medical coverage.

People are **automatically enrolled** in Medicare when first eligible in the following situations:

- If you are already collecting Social Security or Railroad Retirement benefits when you turn 65, you do not have to apply for Medicare. You are enrolled automatically in both Part A and Part B, and your Medicare card is mailed to you about three months before your 65th

birthday. You must have Part A if you are collecting a Social Security benefit; if you wish to decline Medicare Part B benefits, follow the instructions mailed with the Medicare card.

- If you receive Social Security Disability Insurance (SSDI) benefits, you will automatically receive a Medicare card in the mail after you have received Social Security Disability benefits for 24 consecutive months. You must have Part A if you are collecting a Social Security benefit; if you wish to decline Medicare Part B benefits, follow the instructions mailed with the Medicare card.

If you are not collecting Social Security benefits as you approach age 65, and you want your Medicare benefits at age 65, it is important to understand the **three enrollment periods**: Initial Enrollment Period, Special Enrollment Period, and General Enrollment Period. These are detailed below:

Initial Enrollment Period (IEP)

If you are not collecting Social Security benefits when you turn 65 and you wish to enroll in Medicare Part B, you have a seven-month Initial Enrollment Period (IEP) in which to enroll. The IEP includes the three months before you turn 65, the month in which you turn 65, and the three months that follow. When you enroll in Part B will determine when your Part B coverage will begin.

- If you enroll in the **three months prior to your birthday**, your Medicare coverage will be effective the first of the month of your birthday.
- If you enroll in **the month of your birthday**, your coverage will be effective the first of the following month.
- If you enroll in the **month after your birthday**, your coverage will be effective two months later.
- If you enroll **two or three months after your birthday**, your coverage will be effective three months later.

NEW: Starting in 2023, people that enroll in the last 3 months of their IEP will have Part B effective the first of the following month.

Note: For people born on the first of the month, Medicare eligibility starts on the first of the prior month.

Special Enrollment Period (SEP)

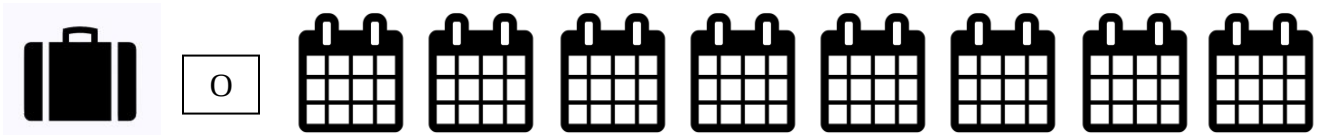
If you have **health insurance** through you or your spouse's current/active employer or union, you may not need to enroll in Medicare Part B when you first become eligible; contact your employer or union to ask if it requires enrollment in Part B.

If you have active employer-based coverage when you are first eligible for Medicare, you will qualify for a SEP to enroll in Part B while still working, or within 8 months following the month in which you lose active employer-based health coverage. You will need the employer to complete form, CMS-L564, documenting employer-based health insurance coverage. The form can be found at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-L564E.pdf . This form is submitted along with CMS-40B, Application for Enrollment in Medicare Part B https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS40B-E.pdf , to Social Security, indicating the desired month for Part B coverage to start, in the Remarks section.

TIPS for those with employer-based coverage:

- ✓ You can no longer contribute to a Health Savings Account (HSA) if you are enrolled in Medicare Part A. See page 8 for information on enrolling in Part A.
- ✓ **COBRA** coverage is NOT health insurance from an active employer and therefore does not qualify you for a Special Enrollment Period.

When Is My Special Enrollment Period?



While you have coverage from your

Any time during the 8 months after the month your employer-based coverage ends

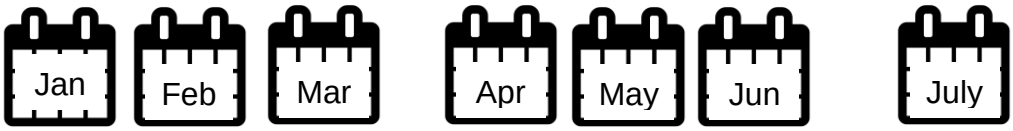
General Enrollment Period (GEP)

If you do not enroll during your IEP and do not qualify for an SEP due to active employer-based coverage, you will have to wait until the General Enrollment Period (GEP) to enroll in Part B. The GEP is from January 1 to March 31 of each year, but Part B coverage will not start until July 1. In addition, you may be subject to a late enrollment penalty. The penalty for late enrollment is 10% of the current standard Part B premium for every full 12 months that you did not have either Medicare Part B or coverage from a current employer. This means that if you delayed Part B enrollment for 12 months, you would be paying the Part B premium + a 10% premium surcharge based on the standard Part B premium for the current year.

NEW: Starting in 2023, people that enroll in the GEP will have Part B effective the first of the following month.

You apply for Medicare benefits by contacting the Social Security Administration. You can call 1-800-772-1213 or visit a local Social Security office. You may also enroll online at www.socialsecurity.gov.

When is the General Enrollment Period?



Enroll in Part B
Jan 1 – March 31

Coverage
begins
July 1

Medicare Part A Enrollment: is more flexible than Part B enrollment. Individuals eligible for premium-free Part A at age 65 can enroll in Medicare Part A at any time, and coverage can be retroactive up to six months, though not before the month they became Medicare-eligible. Those who do not have 40 quarters (credits) of coverage through Social Security can apply for Part A and pay a premium. These individuals can only enroll during the Initial Enrollment Period, and thereafter only during the General Enrollment Period from January 1 through March 31. These individuals may incur a Late Enrollment Penalty.

Medicare Card: All Medicare beneficiaries should have a Medicare card with an ID number, known as a Medicare beneficiary identifier (MBI). The MBI is made up of 11 characters, consisting of both uppercase letters and numbers. If you need to replace your Medicare card, call 1-800-MEDICARE or log into your Medicare.gov account to print one.

Choices in the Medicare Program

Medicare beneficiaries have a choice in how they receive their Medicare benefits (see page 4 for a decision tree). They can either choose Original Medicare, in which they use their red, white, and blue Medicare card for all Part A and Part B covered services, OR they can choose a Medicare Advantage plan, in which a private company provides them with all Medicare benefits. This section below explains how Original Medicare functions, as well as costs in the Original Medicare program. See page 25 for information on Medicare Advantage plans.

Medicare Part A Benefits

Medicare Part A covers inpatient hospital care, skilled nursing facility care, home health care, and hospice care.

Inpatient Hospital Care:
Medicare pays for up to 90 days of medically necessary care in either a Medicare-certified general hospital or a Medicare-certified psychiatric hospital during a benefit period. A **benefit period** starts when you are admitted to the hospital and continues until you have been out of the hospital or skilled nursing facility for 60 consecutive days. After one benefit period has ended, another one will start whenever you next receive inpatient hospital care. Medicare beneficiaries have 60 lifetime reserve days that can be used after day 90 in a benefit period.

Medicare will pay for a lifetime maximum of 190 days of inpatient psychiatric care provided in a psychiatric hospital. After the 190 days of care in a psychiatric hospital have been used up, Medicare will pay for additional inpatient psychiatric care only in a general hospital.

While you are an inpatient, Medicare Part A helps pay for a semi-private room, meals, regular nursing services, rehabilitation services, drugs, medical supplies, laboratory tests, and X-rays. You are also covered for use of the operating and recovery rooms, mental health services, intensive care and coronary care units, and all other medically necessary services and supplies.

Skilled Nursing Facility Care:
Medicare Part A covers care in a skilled nursing facility (SNF) following a stay of at least three days as an inpatient in a hospital (not counting the day of discharge). Medicare will help pay for up to 100 days in a SNF in a benefit period.

Observation Status

People in a hospital may be considered either inpatient or under observation. Those under observation receive outpatient services while their doctor decides whether to admit them as inpatient or discharge them. Hospitals are required to provide Medicare beneficiaries with a Medicare Outpatient Observation Notice (MOON) if they are being held under observation for more than 24 hours. Observation is covered by Part B, not Part A, and does not count toward the minimum three-day inpatient stay required for Medicare Part A to cover care in a Skilled Nursing Facility.

Home Health Care: If you are homebound and require skilled care for an injury or illness, Medicare can pay for care provided in your home by a Medicare-participating home health agency. Home care is covered at 100% by either Part A or Part B. A prior stay in the hospital is not required to qualify for home health care. The services may be provided on a part-time or intermittent basis, not full-time. Coverage is provided for skilled care, including skilled nursing care and physical, occupational, and speech therapy. If you are receiving skilled home care, you may also qualify for other home care services, such as a home health aide and a medical social worker.

Those with both Medicare and Medicaid who receive Medicaid-covered home care services must enroll in a managed long-term care (MLTC) plan. See page 45 for more information on MLTC.

Hospice Care: Medicare beneficiaries who are terminally ill can choose to receive hospice care rather than regular Medicare benefits. Hospice emphasizes providing comfort and relief from pain. It is generally provided at home and can include physical care, counseling, prescription drugs, equipment, and supplies for the terminal illness and related conditions.

Part A Costs (2022)

Premium: Free if you or your spouse have worked and paid into Social Security for at least 40 quarters (10 years).

- Those with less than 40 quarters of coverage with Social Security can purchase Part A coverage.
    - If you have less than 30 quarters of Social Security coverage, your Part A premium will be $499 a month**.** If you have 30 to 39 quarters, your Part A premium will be $274 per month.
    - The QMB Medicare Savings Program may be able to pay the Part A premium for those who do not qualify for premium-free Part A. See page 38.

Inpatient Costs
Deductible: $1,556 per benefit period (covers days 1-60)
Additional cost sharing:

- $389 per day for days 61-90
- $778 per Lifetime Reserve Day (60 days)

Skilled Nursing Facility Costs
Days 1–20: Medicare pays 100%
Days 21–100: You pay $194.50 per day
If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

Medicare Part B Benefits

Part B of Medicare pays for a wide range of medical services and supplies. Most importantly, it helps pay doctor bills. Medically necessary services provided by a doctor are covered whether the care is at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. Part B covers:

- Ambulance transportation
- Blood, after the first 3 pints
- Durable medical equipment
- Flu, COVID-19, pneumonia & hepatitis B vaccines
- Home care (see page 9)
- Injectables
- Lab tests (covered at 100%)
- Medical supplies (including test strips and lancets used with blood glucose monitors)
- Mental health care
- Outpatient hospital services
- Physical, speech & occupational therapy Physician services
- Preventive & screening tests
- X-rays

Medicare does not pay for routine vision (eyeglasses), hearing aids, dental, routine annual physical exams, and other excluded services.

What Do You Pay Under Part B?
Under Medicare Part B, beneficiaries are responsible for a monthly premium, an annual deductible, and coinsurance for most services. Beneficiaries who receive Social Security benefits have the monthly premium deducted from their check. Those who do not collect Social Security will be billed for their premiums typically on a quarterly basis.

Part B Costs (2022)

Standard monthly **premium** is $170.10.

- Those with higher incomes (over $91,000 for individuals, $182,000 for married couples) are responsible for higher premiums, known as the Income Related Monthly Adjustment Amount (IRMAA). Social Security determines whether a person is subject to IRMAA by looking at his or her tax return from two years before; IRMAA is re-evaluated each year. For example, for 2022, SSA looks at your 2020 tax filings. You can request that SSA reconsider your IRMAA amount because of a life-changing event (such as a change in work status) by submitting form SSA-44 (www.ssa.gov/forms/ssa-44-ext.pdf). See page 56 for more information on the current IRMAA amounts.

Annual Deductible: $233

Coinsurance: 20% (Medicare pays 80% of Medicare-approved amount)

Can You Get Help with Cost-Sharing Under Original Medicare?
Several resources can help cover the cost-sharing under Original Medicare:

- **Medicare Supplement Insurance (Medigap)** helps Medicare beneficiaries pay their share of the Medicare approved amount for covered services. These policies fill in the "gaps" of Medicare's reimbursement, but only for services that are approved for Medicare coverage. See page 18 for information on Medigap policies.
- **Retiree/Union Benefits** may work with Original Medicare. Speak to your benefits administrator to understand the policy.
- **Medicaid** helps with Medicare cost-sharing, as long as you meet Medicaid eligibility requirements. See page 42 for more information.

How Much Can Providers Charge for Services?
Doctors and other medical providers can choose to have different relationships with the Medicare program. They can be "Participating" providers or "non-Participating" providers, or they can "Opt Out" of the Medicare program. The provider's relationship affects how much you will pay for his or her services.

- "**Participating**" providers will always accept the Medicare-allowed amount as payment in full (Medicare pays 80% and you pay 20%, after you meet the Part B deductible). If you want to find out whether a provider is participating, you can check the medicare.gov site or call 1-800-MEDICARE.

- "**Non-Participating**" providers still have a relationship with the Medicare program, but they can choose to either "**accept assignment**" or "**not accept assignment**" on each claim. If you learn that a provider is non-participating, ask, "Will the doctor accept assignment for my claim?"
    - If a provider **accepts assignment**, he or she will accept Medicare's approved amount for a particular service and will not charge you more than the 20% co-insurance (for most services), after you have met the Part B deductible.
    - If a provider does **not accept assignment**, the charges are subject to a "Limiting Charge," which is an additional charge over the Medicare-approved amount. The Federal Limiting Charge is 15%. Some states, including New York, have lower limiting charges. In NY, if a physician does not accept assignment for a particular service, they can charge no more than 5% above what Medicare allows for that service, with the exception of home and office visits, where the charge can be up to the 15% Federal limiting charge.
        - **NOTE:** It is common for providers who do not accept assignment to request payment at the time of services. The provider will submit the claim to Medicare and Medicare will reimburse the beneficiary for the 80%.
- Providers who "**Opt Out**" of the Medicare program must enter into a "private contract" with any Medicare beneficiary who seeks their treatment. They will set a fee for each specific service, and you agree to pay the costs, understanding that Medicare will not pay the doctor or reimburse you, and that the provider is not limited by Medicare as to how much they can charge. A Medicare supplement policy (Medigap) will not pay any of these costs either. You are still covered by Medicare for services by other providers, even if they may be referred by the opt-out provider.

Advance Beneficiary Notice of Non-Coverage

There is no prior authorization in Original Medicare (with very limited exceptions). If Medicare considers a service medically necessary, it will pay for the service. If Medicare denies a service as not medically necessary, the beneficiary is not responsible to pay for the service unless they have been notified in advance by the provider using the Advance Beneficiary Notice.

If a provider thinks that Medicare might not consider a service "medically necessary," and therefore not approve a claim, the provider may present you with an "Advance Beneficiary Notice of Non-coverage (ABN)" form. The form must specify the service in question, and a specific reason why the service may not be paid by Medicare. It must also include a place for you to sign as proof that you understand and accept responsibility to pay for the service. You are not responsible to pay unless you signed a valid ABN. The ABN does not apply to services never covered by Medicare (e.g., hearing aids), which are always your responsibility. You retain appeal rights, even with a signed ABN. See page 13 for a sample ABN.

Medicare Summary Notice

Beneficiaries are encouraged to sign up to receive electronic Medicare Summary Notice (e-MSN) information online. Otherwise, a Medicare Summary Notice (MSN) statement will be mailed quarterly to each Medicare beneficiary for whom a Part A and/or Part B claim was submitted by a provider who accepts Medicare assignment. For claims from providers who do not accept Medicare assignment, an MSN will be mailed as the claims are processed, along with a check to the beneficiary.

The MSN also contains information on how you can appeal Medicare claim denials.

Beneficiaries can also call 1-800-MEDICARE or log on to their account on medicare.gov for their

claim information. They can request to receive the MSN in Spanish by calling 1-800-MEDICARE.

Medicare Appeals

If you disagree with a Medicare coverage or payment decision, you can file an appeal with Medicare. The Medicare Summary Notice (MSN) has information on the appeals process. You may need to request additional information from your health care provider to support your case. Pay attention to the time limit for filing an appeal.

For quality-of-care complaints or if you feel your Medicare Part A or B services are ending too soon, for instance if you believe you are being discharged from the hospital prematurely, call Livanta at 1-877-588–1123 (TTY: 1-855- 887-6668).

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

MEDICARE PREVENTIVE SERVICES

Nearly all preventive services are covered by Medicare at 100%, and not subject to the Part B deductible and/or 20% coinsurance. Medicare provides coverage for the following preventive services:

Abdominal aortic aneurysm screening	Medicare covers an abdominal aortic screening ultrasound once if you have a family history of abdominal aortic aneurysms or are a man age 65-75 and have smoked at least 100 cigarettes in your lifetime.
Alcohol misuse screening and counseling	Medicare covers an annual screening for alcohol misuse. For those who screen positive, Medicare will also cover up to four brief, face-to-face behavioral counseling interventions annually.
Bone mass measurements	Medicare covers bone mass measurements to identify bone loss or determine bone density every 24 months. Women at risk for osteoporosis or who are receiving osteoporosis drug therapy may be eligible more frequently.
Breast cancer screening (mammogram)	One baseline mammogram is covered between ages 35 and 39. All women with Medicare, aged 40 and older, are provided with coverage for a screening mammogram every 12 months. A diagnostic mammogram is covered at any time there are symptoms of breast cancer. The diagnostic mammogram is subject to the Part B deductible and 20% co-insurance.
Cardiovascular disease (behavioral therapy)	Medicare covers one CVD risk reduction visit annually. The visit encourages aspirin use, screening for high blood pressure, and behavioral counseling to promote a healthy diet.
Cardiovascular disease screening	Medicare covers cardiovascular screenings that check cholesterol and other blood fat (lipid) levels once every 5 years.
Cervical and vaginal cancer screening (Pap smear and pelvic exam)	A pap test, pelvic exam and clinical breast exam are covered every 24 months, or once every 12 months for women at higher risk for cervical or vaginal cancer. All women with Medicare are covered. Part B also covers Human Papillomavirus (HPV) tests (as part of Pap tests) once every 5 years for women age 30-65 without HPV symptoms.
Colorectal cancer screening	• Fecal Occult Blood Test is covered once every 12 months. • Flexible Sigmoidoscopy is covered once every 48 months. • Colonoscopy is covered once every 24 months for those at higher risk for colon cancer. For those not at higher risk it is covered once every 10 years but not within 48 months of a screening flexible sigmoidoscopy. • Barium Enema: this can be substituted for a flexible sigmoidoscopy or colonoscopy; you pay 20% of the Medicare-approved amount. • Multi-target stool DNA tests: covered once every 3 years for people with Medicare who are between 50 and 85 years old; show no signs or symptoms of colorectal disease; and are at average risk of developing colorectal cancer.
Depression screening	Medicare covers depression screenings in a primary care setting once every 12 months.
Diabetes screening	Medicare covers up to 2 screenings per year for people at risk for diabetes.

Diabetes prevention program	Medicare covers a one-time health behavior change program to help prevent type 2 diabetes for people who meet the clinical requirements and who have never been diagnosed with type 1 or type 2 diabetes or End-Stage Renal Disease (ESRD).
Diabetes self-management training	Medicare covers training for people with diabetes on how to manage their condition and prevent complications.
Glaucoma tests	People at high risk for glaucoma, including those with diabetes or a family history of glaucoma, are covered once every 12 months. You pay 20% of the Medicare-approved amount after the Part B deductible.
Hepatitis B virus infection screening	Medicare covers an annual Hep B screening for those at risk who do not get a Hep B shot; Medicare also covers Hep B screening for those who are pregnant.
Hepatitis C screening test	Medicare covers one Hepatitis C screening test for people born between 1945 and 1965, and a yearly repeat screening for people at high risk.
HIV screening	Covered once every 12 months for any beneficiary who requests the test.
Lung cancer screening	Medicare covers lung cancer screening every 12 months for people age 50-77 who either smoke currently or have quit within the last 15 years.
Medical Nutrition therapy	Medicare covers 3 hours of one-on-one counseling services the first year, and 2 hours each year after that for beneficiaries with diabetes or kidney disease.
Obesity screening and counseling	If you have a body mass index of 30 or more, Medicare covers a dietary assessment as well as intensive behavioral counseling and behavioral therapy.
Physical exam	An initial preventive physical exam is covered during the first twelve months of Medicare Part B enrollment. Also, an annual wellness visit is covered for all people with Medicare Part B, but not within 12 months of the initial exam.
Prostate cancer screening	Digital Rectal Examination is covered once every 12 months for men aged 50 and older. You pay 20% of the Medicare-approved amount after the Part B deductible. Prostate Specified Antigen (PSA) blood screening test is covered once every 12 months for men aged 50 and older.
Sexually transmitted infections (STIs) screening and counseling	Medicare covers screening for chlamydia, gonorrhea, syphilis, and Hepatitis B, as well as high intensity behavioral counseling (HIBC) to prevent STIs. The screening tests are covered once every 12 months, in addition to up to two individuals 20-to-30-minute, counseling sessions annually for those at increased risk for STIs.
Tobacco use cessation counseling	Medicare will cover up to 8 face-to-face counseling sessions on stopping smoking during a 12-month period for beneficiaries who use tobacco.
Vaccinations/shots	COVID-19 Flu is covered once per flu season Pneumonia is usually needed only once in a lifetime. A different, second shot is covered 12 months after you get the first shot. Hepatitis B is covered if at high or intermediate risk.

MEDICARE AS SECONDARY PAYER WHO PAYS FIRST?

If you have Medicare along with other health insurance coverage, you need to understand which is primary, and which is secondary. The primary insurance will consider the claim first and the secondary insurance will consider any balance remaining after the claim has been paid or denied by the primary insurance.

Individuals who are new to Medicare will receive a letter in the mail asking them to complete the Initial Enrollment Questionnaire (IEQ). This questionnaire asks if you have group health plan coverage through your employer or a family member's employer. The IEQ can be completed online, at your Medicare.gov account, or over the phone by calling 1-855-798-2627.

If you have questions about who pays first, or if your coverage changes, call the Medicare Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627.

This chart shows who pays first in cases when you have Medicare and insurance from a <u>current</u> employer:

YOU ARE…	YOUR EMPLOYER HAS…	MEDICARE WILL PAY…
65+ covered by employer plan	Less than 20 employees	First - Employer plan second.
65+ covered by employer plan	20 or more employees	Second - Employer plan first.
65+ covered by spouse's employer plan	Less than 20 employees	First - Employer plan second.
65+ covered by spouse's employer plan	20 or more employees	Second - Employer plan first.
Disabled under 65 covered by employer plan	Less than 100 employees	First - Employer plan second.
Disabled under 65 covered by employer plan	100 or more employees	Second - Employer plan first.
Disabled under 65 covered by other family member's plan	Less than 100 employees	First - Employer plan second.
Disabled under 65 covered by other family member's plan	100 or more employees	Second - Employer plan first.
Any age with End Stage Renal Disease (ESRD) covered by own employer plan or family member	Any number of employees	Second for the first 30 months of Medicare enrollment. After 30 months, Medicare is primary.

Employer Group Health Plans (EGHP) and Medicare: When people have both employer coverage and Medicare, the size of the employer determines whether Medicare is the primary or secondary insurer.

- **Working after age 65:** If you have health insurance coverage through your or your spouse's active employment, and the employer has 20 or more employees, the EGHP is primary, and Medicare is secondary. If the employer has fewer than 20 employees, then Medicare is primary and the EGHP is secondary. Some employers require that employees eligible for Medicare enroll in Medicare Part A and/or B; it is advised to contact the employer about this issue.

  As you approach retirement, you need to consider enrolling in Medicare Part B, since it will be the primary insurance when you retire. See page 7 for information on Medicare's Special Enrollment Period.

- **Disability and Medicare:** If you have health insurance coverage based on your own, your spouse's or another family member's active employment, with an employer of 100 or more employees, the EGHP is primary, and Medicare is secondary. If the employer has fewer than 100 employees, then Medicare is primary and the EGHP is secondary.

- **End Stage Renal Disease (ESRD):** Some individuals are eligible for Medicare coverage because they have End Stage Renal Disease and are either receiving maintenance dialysis treatments or have had a kidney transplant. If they have an EGHP (regardless of whether it is based on current employment), that coverage is primary during the first 30 months of Medicare eligibility. After 30 months, Medicare is primary.

- **Worker's Compensation and Medicare:** Worker's Compensation is usually primary in the event of a job-related injury and covers only health care expenses related to the injury.

- **Liability Insurance and Medicare**: In the case of an accident or injury, medical care expenses may be covered by other types of insurance such as no-fault or automobile insurance, homeowners, or malpractice policies. Since many liability claims take a long time to be settled, Medicare can make conditional payments in this situation to avoid delays in reimbursement to providers and beneficiary liability. Medicare will pay the claim and later seek to recover the conditional payments from the settlement amount. The Benefits Coordination & Recovery Center (BCRC) assists with this function.

Retiree Health Coverage: Generally speaking, if you have both Medicare and retiree health insurance, Medicare is primary and retiree coverage is secondary. Some retiree benefits work more like a supplement to Original Medicare, while others act more like a Medicare Advantage plan. You must speak to the benefits administrator to understand how your retiree benefits coordinate with Medicare.

Federal Employee Health Benefits (FEHB): Unlike most retiree plans which require enrollment in Medicare, the Federal Employees Health Benefits (FEHB) program can continue to pay as primary if you do not enroll in Medicare. FEHB retirees can choose to enroll in Part B or not. They have three options:

1. FEHB and NO Part B. Members can continue with their FEHB coverage without signing up for Medicare, which will save them the cost of the monthly Part B premium. However, if these members later decide they want Part B, they will need to wait until the next General Enrollment Period to sign up for Part B and may be subject to a late enrollment penalty.

2. FEHB and Part B. Members can continue with their FEHB coverage and also enroll in Part B. Some FEHB plans may provide an incentive to enroll in Medicare, such as waiving FEHB plan co-payments, deductibles, and coinsurance. Members electing to participate in both Medicare and FEHB will need to pay both the FEHB and Part B premiums.
3. Part B and NO FEHB. Unlike most retirees, Federal retirees can SUSPEND (not cancel) their retiree coverage to enroll in a Medicare Advantage plan, which may have a lower monthly premium or no added premium at all. Individuals choosing this option will still need to enroll in Part B in order to be eligible to enroll in a Medicare Advantage plan, but they will avoid the higher cost of the FEHB premium. Additionally, they may elect to return to FEHB coverage during the next FEHB Open Enrollment period.

Visit the Office of Personnel Management (OPM) website for more information about Medicare and FEHB at http://www.opm.gov/insure/health/medicare/index.asp, http://www.opm.gov/healthcare-insurance/fastfacts/fehbmedicare.pdf, and http://www.opm.gov/healthcare-insurance/healthcare/medicare/75-12-final.pdf.

MEDICARE SUPPLEMENT INSURANCE (Medigap)

Medicare Supplement Insurance (Medigap) is specifically designed to help with the costs sharing associated with Original Medicare Parts A and B coverage. Regulated by federal and state laws, the policies can only be purchased from private companies. You must have Medicare Parts A and B to purchase a Medigap policy. Medigap policies sold today do not include drug coverage.

Why do I need a Medigap policy?
A Medigap policy pays your share of out-of-pocket health service costs covered by Medicare. For example, a Medigap policy might cover the Part A deductible, the Part B outpatient coinsurance of 20% of allowed charges, and other costs. **Note: some plans cover only a percentage of these costs, while other plans cover them in full.** Medicare Advantage plan enrollees should not enroll in a Medigap plan, as this would duplicate coverage, they have through their Medicare Advantage plan.

What Medigap plans are available?
There are ten standard Medigap plans available, designated "A" through "N." All the plans cover the basic benefit package: plans B through N combine this with an array of additional benefits. Medigap plans E, H, I and J are no longer offered to new enrollees; individuals with these policies can maintain their existing coverage but may wish to compare benefits with the premium cost to determine whether their plan remains cost effective. They should bear in mind, however, that if they decide to switch to a new plan, they will not be allowed to go back to their old plan.

Individuals newly eligible for Medicare on or after January 1, 2020, are not able to purchase Medigap Plan C or Plan F, including high deductible Plan F.

When can I buy a Medigap policy?
In New York State, you can purchase a Medigap policy at any time once you are enrolled in Medicare. You are guaranteed the opportunity to purchase a policy even if you are under age 65 and have Medicare due to disability.

When can I switch Medigap policies?
In New York State, you can switch the company from which you get the Medigap policy, as well as the type of Medigap policy, at any time. Some companies require you to remain in a plan for a certain period before switching to a different plan that they offer. However, you can still get the desired plan from a different company that offers it.

How do I choose a Medigap policy?
Since Medigap plans are standardized, you first need to decide the level of coverage you need. Once you establish which set of benefits is right for you, you can compare the premium, service and reputation of the insurance companies offering the plan that suits your needs. Most Medigap insurers have an arrangement with Medicare where your claims are forwarded electronically from Medicare to the Medigap insurer, so that you and your provider do not need to submit a claim to your Medigap plan separately. Companies can bill the policy premium monthly, quarterly, or annually; your preference may be for a particular payment schedule.

How am I protected?
All standard Medigap policies sold today are guaranteed renewable. The insurance company cannot refuse to renew the policy unless you do not pay the premiums, or you made misrepresentations on the application. Federal law prohibits an insurance company or salesperson from selling you a second Medigap policy that duplicates the coverage of one you already have, thus protecting you from pressure to buy more coverage than you need. You can switch Medigap policies whenever you require a different level of coverage. For example, when your health needs are greater, you can arrange to purchase a Plan G, if you find plan B is too limited. The new Medigap policy would replace the previous one. DO NOT CANCEL THE OLD POLICY UNTIL THE NEW ONE IS IN EFFECT.

How are premiums determined?
In New York State, you are protected by "community rating." The monthly premium set by an insurance company for one of its standard Medigap policies must be the same for all individuals in a certain geographic area regardless of their age, gender or health condition. See page 24 for a listing of insurance companies and their premiums for Medicare beneficiaries in New York City.

When will my coverage start if I have a pre-existing health condition?
The maximum period that Medigap coverage can be denied for a pre-existing health condition is the first six months of a new policy and only for claims that are directly related to that condition. A pre-existing condition is one for which medical advice was given, or treatment recommended by, or received from, a physician within six months before the effective date of coverage. You may qualify for **immediate** coverage for a pre-existing health condition if (1) you buy a policy during the open enrollment period when you are first eligible for Medicare at age 65 or (2) you were covered under a previous health plan for at least six months without an interruption of more than 63 days. If your previous health plan coverage was for less than six months, your new Medigap policy must credit you for the number of months you had coverage. Some insurers have shorter waiting periods for pre-existing conditions. A chart with the waiting periods for pre-existing conditions can be found online at www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates.

What paperwork will I receive from my Medigap insurer?
A Medigap insurance company is required to send you an Explanation of Benefits (EOB) to document that it paid its portion of your claims. The EOB, combined with the Medicare Summary Notice (MSN) you receive from Medicare gives you the total information about how your health care claim was processed.

STANDARD MEDIGAP PLANS

Below are descriptions of the ten standard Medigap plans, Plans A–N, with the benefits provided by each:

PLAN A (the basic policy) provides these **basic benefits:**

- Coverage for the Part A copayment ($389 per day in 2022) for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for the Part A copayment ($778 per day in 2022) for each of Medicare's 60 non-renewable inpatient hospital lifetime reserve days.
- After all Medicare hospital benefits are exhausted, coverage of 100% of eligible Medicare Part A hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for Medicare Part A hospice care cost-sharing.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells) per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance for Part B services (generally 20% of the Medicare approved amount), after the annual deductible is met ($233 in 2022).

PLAN B includes the **basic benefits, plus**

- Coverage for the Medicare Part A inpatient hospital deductible ($1,556 per benefit period in 2022).

PLAN C[1] includes the **basic benefits, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care copayment ($194.50 per day for days 21 through 100 per benefit period in 2022).
- Coverage for the Medicare Part B deductible ($233 per calendar year in 2022).
- Coverage for 80% of the cost of medically necessary emergency care in a foreign country, after a $250 deductible, with a $50,000 lifetime maximum benefit.

PLAN D includes the **basic benefits, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily copayment.
- Coverage for 80% of the cost of medically necessary emergency care in a foreign country, after a $250 deductible with a $50,000 lifetime maximum benefit.

[1] Plans C, F, and F+ are only available to individuals who first became eligible for Medicare prior to January 1, 2020.

PLAN F[1] includes the **basic benefits, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily coinsurance.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges, also known as limiting charge [2].
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible with a $50,000 lifetime maximum benefit.

PLAN F+[1] **(high deductible)**

- Same benefits as the Standard Plan F, but beneficiaries must satisfy a high deductible ($2,490 in 2022) before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums.

PLAN G includes the **basic benefits, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily copayment.
- Coverage for 100% of Medicare Part B excess charges, also known as limiting charge[1].
- Coverage for 80% of the cost of medically necessary emergency care in a foreign country, after a $250 deductible, with a $50,000 lifetime maximum benefit.

PLAN G+ (high deductible)

- Same benefits as the Standard Plan G, but beneficiaries must satisfy a high deductible ($2,490 in 2022) before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums. Although Plan G does not cover the Part B deductible, the amount that you pay towards that deductible is credited towards the G+ deductible.

Medigap plans E, H, I and J are no longer sold to new policyholders. However, individuals who currently have an E, H, I, or J plan can keep their policies.

PLAN K[3] includes the **basic benefits, plus**

- Coverage for 50% of the Medicare Part A inpatient hospital deductible.
- Coverage for 50% of Part B coinsurance after you meet the yearly deductible for Medicare Part B, but 100% of the coinsurance for Part B preventive services.
- Coverage for 100% of the Part A copayment for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A copayment for each of Medicare's 60 non- renewable inpatient hospital lifetime reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient

[2] The plan pays the difference between Medicare's approved amount for Part B services and the limiting charge set by either Medicare or state law.

[3] The basic benefits for plans K, L, and N are similar to those for plans A–G, but with some different levels of cost - sharing. The annual out-of-pocket limits for plans K and L can change each year.

hospital care during the policyholder's lifetime.
- Coverage for 50% of hospice cost-sharing.
- Coverage for 50% of Medicare-eligible expenses for the first 3 pints of blood.
- Coverage for 50% of the skilled nursing facility care daily copayment.
- Annual out of pocket limit of $6,620 in 2022.

PLAN L[3] includes the **basic benefits, plus**
- Coverage for 75% of the Medicare Part A inpatient hospital deductible.
- Coverage for 75% of Part B coinsurance after you meet the yearly deductible for Medicare Part B, but 100% of the coinsurance for Part B preventive services.
- Coverage for 100% of the Part A copayment for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A copayment for each of Medicare's 60 non- renewable hospital inpatient lifetime reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for 75% hospice cost-sharing.
- Coverage for 75% of Medicare-eligible expenses for the first 3 pints of blood.
- Coverage for 75% of the skilled nursing facility care daily coinsurance.
- Annual out of pocket limit of $3,310 in 2022.

Plan M includes the **basic benefits, plus**
- Coverage for 50% of the Medicare Part A inpatient hospital deductible.
- Coverage for 100% of the skilled nursing facility daily copayment.
- Coverage for 80% of the cost of medically necessary emergency care in a foreign country, after a $250 deductible, with a $50,000 lifetime maximum benefit.

Plan N[3] includes the **basic benefits, plus**
- Coverage for 100% of the Medicare Part A inpatient hospital deductible.
- Coverage for 100% of the Medicare Part B coinsurance amount, except for co-payments of up to $20 for office visits and $50 for emergency room visits.
- Coverage for 100% of the skilled nursing facility daily copayment amount.
- Coverage for 80% of the cost of medically necessary emergency care in a foreign country, after a $250 deductible, with a $50,000 lifetime maximum benefit.

[3] The basic benefits for plans K, L, and N are similar to those for plans A–G, but with some different levels of cost - sharing. The annual out-of-pocket limits for plans K and L can change each year.

BENEFITS INCLUDED IN THE TEN STANDARD MEDICARE SUPPLEMENT PLANS

Basic Benefits: Included in all plans

- **Hospitalization:** Part A copayment, coverage for 365 additional days after Medicare benefits end, and coverage for 60 lifetime reserve days copayment.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses).
- **Blood:** First 3 pints of blood each year.
- **Hospice:** Part A cost sharing.

A	B	C	D	F*	G*	K	L	M	N
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits**	Basic Benefits**	Basic Benefits	Basic Benefits**
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance (50%)	Skilled Nursing Coinsurance (75%)	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible (50%)	Part A Deductible (75%)	Part A Deductible (50%)	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess	Part B Excess				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out of Pocket limit $6,620	Out of Pocket limit $3,310		

*Plan F and Plan G are also offered with a high deductible option.
**These plans cover the basic benefits but with some different cost-sharing requirements.

Updated March 2022

MEDICARE SUPPLEMENT INSURANCE POLICIES

Please call the individual companies directly for their most current monthly rates as they are subject to change. Updated rate charts are available at the NYS Department of Financial Services website: https://www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates .

PLAN	Aetna (800) 345-6022	Bankers Conseco (800) 845-5512	Emblem (formerly GHI) (800) 444-2333	Empire Blue Cross Blue Shield (855) 306-9355	Globe Life Insurance* (800) 331-2512	Humana (800) 486-2620	Mutual of Omaha (800) 228-9999	TransAmerica Financial (800) 752-9797	United Health (AARP) - Must be an AARP member to enroll (age 50+) (800) 523-5800
A	$318.21	$413.54	$194.87	$179	$240/268	$321.19	$351.72	$195	$188.50
B	$362.44	$540.65	$253.28	$241.11	$328/368	$362.61	$512.25	$257	$270.50
C**			$300.87		$397/444	$439.46	$512.82	$304	$332.25
D					$391/438		$503.90	$280	
F**	$422.90	$729.96	$530.29	$337.83	$374/419	$448.38	$516.15	$306	$320.00
F+**		$75.69	$74		$72/$81	$93.09			
G	$406.26	$671.84	$302	$291.75	$348/390	$400.38	$478.04	$281	$280.25
G+		$75.69	$67.69		$72/$81	$92.97			
K		$112.08			$137/154	$209.34		$140	$88.00
L		$322.45			$206/231	$298.98		$208	$182.75
M		$446.65					$526.10	$256	
N		$439.55	$220	$207.60	$259/290	$284.05		$241	$211.25

*Globe Life Insurance (formerly First United American) premiums differ by zip code. Use above link to find rates where you live.
** Only individuals who were Medicare eligible prior to January 1, 2020, can purchase Medigap Plans C, F and F+.

MEDICARE ADVANTAGE PLANS
HMO, PPO, HMO-POS, SNP

Medicare Advantage (MA) plans provide beneficiaries with alternatives to Original Medicare. Medicare Advantage plans are offered by private companies and include the following types: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), HMOs with Point-of-Service option (HMOs-POS), and Special Needs Plans (SNPs). The companies that offer Medicare Advantage plans contract with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare benefits to enrollees.

To be eligible to join a Medicare Advantage plan, you must have both Medicare Part A and Part B and live in the plan's service area. A Medicare Advantage plan cannot turn away an applicant because of health problems (or impose a waiting period for pre-existing conditions).

Joining a Medicare Advantage plan is a choice. Medicare Advantage plans must cover all the medically necessary services covered by Part A and Part B of Medicare, and typically include additional benefits, such as coverage for prescription drugs, and vision, dental, and hearing services. If you wish to have Medicare **Part D prescription drug coverage** and belong to a Medicare Advantage plan, you must get the Part D drug coverage through your plan; you cannot join a separate Part D plan. All Medicare beneficiaries have the right to obtain needed medical services, to get full information about treatment choices from their doctors, and to appeal any denial of services or reimbursement made by a Medicare Advantage plan.

If you join a Medicare Advantage plan you CANNOT purchase a Medigap policy, as that would duplicate coverage.

Each member of a Medicare Advantage plan must receive a Summary of Benefits as part of the enrollment process. Key information about additional premiums, routine procedures, access and notification requirements in an emergency, and co-payments for services must be outlined. A provider directory, a list of pharmacies in the plan, and a formulary list of covered medications are also available from the plan.

Medicare Advantage plans have <u>networks</u> of doctors, health centers, hospitals, skilled nursing facilities, and other care providers. These networks can be local, statewide, and even national. It is important to contact the plan to understand the scope of the provider network, especially if you travel and may require care (other than emergency care) outside your area of residence.

HMOs - require the Medicare beneficiary to select a primary care physician (PCP) from their networks of doctors. Within that network, you have a choice of physician, provided that he or she is accepting new patients. Some HMOs require referrals for specialist services. You must receive your health care from providers in your HMO's network. Except for emergency care, there is no coverage for services obtained from out-of-network providers; the beneficiary will be responsible for the full costs of such services.

PPOs - have networks of health care providers and hospitals but <u>do not restrict</u> enrollees from going out-of-network. The PPO sets fixed co-payments for services enrollees receive from in-

network providers; enrollees will pay more for services from out-of-network providers. (Out-of-network providers are subject to Medicare's limiting charge, which limits the amount they can charge a Medicare beneficiary for services.)

HMO/POS - is similar to a PPO plan. Members have a greater flexibility than with an HMO because they can use both in-network and out-of-network providers. However, HMO-POS plans may not cover <u>all</u> benefits out-of-network. For example, a plan may only offer in-network inpatient hospital coverage. Contact the plan for details.

SNPs - are Medicare Advantage plans that are available only to certain groups of people with Medicare – for example, people with both Medicare and Medicaid; people with certain chronic conditions; and people living in an institution, such as a nursing home. Coverage is provided for services covered by Medicare Parts A and B, as well as Part D prescription drugs. SNPs may also cover additional services that may be needed by the specific population to which they are geared.

A list of Medicare Advantage plans can be found in the U.S. Government's handbook *Medicare and You*. Details of the plans are available on www.medicare.gov or by **calling 1-800-MEDICARE**

Enrolling in a Medicare Advantage (MA) Plan: those newly eligible for Medicare can enroll during their Initial Coverage Election Period (ICEP).

For most people, the ICEP is the 7-months surrounding the month in which they are first Medicare eligible. Their plan will be effective the first month of Medicare eligibility, or the month following the month of enrollment. Beneficiaries who delay Part B enrollment will have their ICEP extended to allow them to enroll in a MA plan in the months prior to Part B starting, so that their Medicare Advantage plan will be effective the same month as their Part B. Enrollment can be done online at www.medicare.gov, by calling 1-800-MEDICARE, or by contacting the plan directly.

People who enroll in a MA plan when first eligible for Medicare (during their ICEP) have an **Open Enrollment Period**, which allows them three months from when they are first entitled to Medicare to switch to a different MA plan, or to change to Original Medicare (with or without a Part D plan).

All beneficiaries in MA plans also have an Open Enrollment period at the beginning of the year, from January 1 – March 31. During this time, they can switch to a different Medicare Advantage plan or change to Original Medicare, with the change effective the first of the following month, either February 1, March 1, or April 1. To make this change, you simply enroll in either a new Medicare Advantage plan or if you want to switch to Original Medicare, in a stand-alone Part D plan. This enrollment will automatically disenroll you from the previous Medicare Advantage plan.

SEP65 - is a Special Enrollment Period available to people eligible for Medicare due to age (not disability) who enroll in an MA plan during the Initial Coverage Election Period (ICEP) surrounding the month of their 65th birthday. It allows them 12 months from the time the MA

plan is effective to switch to Original Medicare (not to another MA plan).

Annual Election Period (AEP): From October 15 through December 7, you can enroll in a new Medicare Advantage (MA) plan or switch from a MA plan to Original Medicare, or switch from Original Medicare to a MA plan, with the change effective January 1.

LIS Special Enrollment Period (SEP): Beneficiaries with Extra Help can switch plans once per quarter during the first nine months of the year (January – March; April – June; July – September), with the change effective the first of the following month. Individuals can enroll in a new Medicare Advantage plan or switch from a MA plan to Original Medicare or switch from Original Medicare to a MA plan with a Part D plan.

Tips for Switching Between Original Medicare and Medicare Advantage

- Medicare Advantage to Original Medicare: Select and enroll in a Part D plan that works with Original Medicare; this will trigger disenrollment from the MA plan. Consider supplemental coverage, such as Medigap.
- Medicare Advantage to Medicare Advantage: Enroll in the desired Medicare Advantage plan; this will trigger disenrollment from the original MA plan.
- Original Medicare to Medicare Advantage: Enroll in the desired Medicare Advantage plan; this will trigger disenrollment from your Part D plan that works with Original Medicare. You may wish to cancel your supplemental coverage.

Medicare Advantage Appeals

Appeals of decisions by your plan not to provide or pay for a service are handled by the plan's claims department. The appeals process for Medicare Advantage plan enrollees works differently depending on whether you have not yet received the service, have already received the service, or are appealing denials for prescription drugs. Pay attention to the time limit for filing appeals.

Medicare Advantage plan enrollees who are denied coverage for a health service or item before receiving the service or item, can appeal to the plan to reconsider its decision. Follow the steps on the Notice of Denial of Medical Coverage.

If a Medicare Advantage plan denies coverage for a health service or item that you have already received, you may choose to appeal to your plan to reconsider its decision. Follow the steps on the Explanation of Benefits or on the Notice of Denial of Payment.

The appeals for denial of prescription drug coverage are the same for people whether you are in Original Medicare or a Medicare Advantage plan. See page 33 for Part D coverage appeals.

For quality-of-care complaints, or if you feel your Medicare Part A or B services are ending too soon, such as that you are being discharged from the hospital prematurely, call Livanta at 1-877-588–1123 (TTY: 1-855- 887-6668).

Frequently Asked Questions about Medicare Advantage Plans

What are my out-of-pocket costs in a Medicare Advantage plan?
Each Medicare Advantage plan sets its own premiums and cost-sharing. You may pay a monthly premium directly to the plan, which is in addition to the monthly Medicare Part B premium. All cost sharing requirements must be clearly indicated to you on your benefit card or in your summary of benefits. Call the plan if you are not sure. **There may be co-pays, coinsurance, and deductibles for health services. Make sure you understand the different out-of-pocket costs for a primary care visit, specialist visit, inpatient hospital stays, prescription drugs, and other services.**

All Medicare Advantage plans are required to set a limit on how much you will have to pay out-of-pocket in a given calendar year for Part A and Part B covered services, termed your maximum out-of-pocket (MOOP). In 2022, MOOP cannot exceed $7,550 for in-network services in HMO plans and $11,300 for combined in-network and out-of-network services in PPO plans.

What about emergency services?
Emergency medical care will be covered by your Medicare Advantage plan provided that you follow its requirements for notifications and approval. You may be required to pay the provider of services first, and then file a claim with the plan for reimbursement. If the plan determines that your need for the care did not meet its conditions, or if the notification was faulty, it may refuse to cover the costs.

How do I complain about quality of care?
If your complaint is related to the quality of health care you receive, you should follow your plan's grievance procedures. You can also present your case to the Medicare Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), Livanta in New York State, whose doctors and other professionals review the care provided to Medicare patients. Livanta can be reached at 1-866-815-5440.

What differences are there between obtaining services with Original Medicare vs. Medicare Advantage?
With Original Medicare, the beneficiary can obtain medically needed services from any Medicare provider anywhere in the United States. Medicare sets the fees for those services and covers 80% of most costs. The beneficiary is responsible for the balance. Medicare supplement insurance, also known as Medigap (see page 18), can cover all or most of the beneficiary's share of the costs. Medicare Advantage plans are managed care plans and operate differently. They have their own cost structures which can include premiums, deductibles, co-payments and maximum out-of-pocket costs.

How should I decide whether to join a Medicare Advantage plan and which plan might be right for me?

You should consider the following before joining a plan: Your current doctors' participation in the plan; hospitals' participation in the plan; the plan's prescription drug coverage; its costs; and its geographical service area. It is vital to review this information each year during the Annual Election Period (October 15 – December 7).

1. **Your doctors' participation in the plan:** Ask your doctors what plans they participate in and whether they are accepting new Medicare patients under that plan. Even if you already have an established relationship with particular doctors, you need to be certain that they will accept you as a new patient under that plan. Confirm provider participation each year.
2. **Hospital participation in the plan:** Make sure that any hospitals you use, and any that you would like to have access to, participate in the plan, or would allow you to access them on an out-of-network basis.
3. **Prescription drug coverage:** Check how the plan would cover your prescription drugs (formulary, restrictions, cost) by using the Medicare.gov Plan Finder (see page 32).
4. **Costs:** Receiving care through a Medicare Advantage plan may cost you less than receiving care through Original Medicare. Medicare Advantage plans may also cover services which are not covered by original Medicare, such as routine vision and dental care, as well as hearing aids. Research a Medicare Advantage plans's fee structure (premium, copays, deductible, maximum out-of-pocket costs, etc.) before enrolling.
5. **Geographical Service Area:** HMO plans have defined geographic areas that they serve but must also cover emergency care outside their service area. If you expect to be outside an HMO's service area for any length of time, check if it will cover you there. The service areas of PPO and HMO-POS plans are less restrictive, but you should still be aware of what they are.
6. **Star ratings:** Every plan has a star (quality) rating based on criteria measured by Medicare.

Will I need a Medicare supplement insurance policy?

You will not need a Medicare supplement insurance policy ("Medigap") if you join a Medicare Advantage plan, since Medigap insurance only works with Original Medicare. If you decide to join a Medicare Advantage plan, and you already have a Medigap policy, you may want to retain it temporarily, while you determine if the Medicare Advantage plan is satisfactory. By New York State law, you will always be able to purchase a Medigap policy if you leave a Medicare Advantage plan and return to original Medicare, but you may face a period of non-coverage for a current health condition if you have a gap in coverage. For more about Medigap, see page 18.

MEDICARE PART D – PRESCRIPTION DRUG COVERAGE

Medicare Part D is coverage offered through private insurance companies to help beneficiaries with the cost of prescription drugs.

Medicare prescription drug plans are available to all people with Medicare (Part A and/or Part B). Part D is an optional and voluntary benefit; Medicare beneficiaries are not required to join a plan, although there may be a penalty for late enrollment.

Medicare Part D is offered through private companies that have contracted with the federal government to provide Medicare Part D drug coverage to Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) regulates the plans and categories of covered drugs. Each Part D plan has its own list of covered medications (formulary) and participating pharmacies, as well as its own procedures beneficiaries must follow to get coverage for a new drug or for a medication, they require to meet their special needs.

You can obtain Medicare Part D coverage in one of two ways:

1. **Through a Stand-Alone Prescription Drug Plans (PDP):** PDPs work with Original Medicare and ONLY cover prescription drugs.
2. **Through a Medicare Advantage plan with Prescription Drug coverage (MA-PD):** These are managed care plans, such as HMOs, PPOs, HMO-POS, or SNPs, which offer comprehensive benefits packages that cover all the following: hospital, doctors, specialists, pharmacy, and prescriptions. If you are in a Medicare Advantage plan and want to have Part D coverage, you must get it through your Medicare Advantage plan.

Those electing to join a Part D plan will have to pay a monthly premium and pay a share of the cost of prescriptions. Drug plans vary in what prescription drugs are covered (formulary), how much you must pay (premium, deductible, copays), and which pharmacies you can use (network). All drug plans must provide at least a standard level of coverage, that Medicare sets. However, some plans offer enhanced benefits and may charge a higher monthly premium. When you join a drug plan, it is important that you choose one that meets your prescription drug needs.

Beneficiaries with higher incomes (above $91,000 for an individual or $182,000 for a couple in 2022) will pay a surcharge for Part D in addition to their plan premium. The surcharge ranges from $12.40 to $77.90 per month in 2022 and is paid in the same way as the Part B premium, typically as a deduction from the beneficiary's Social Security check (see page 56 for rate chart).

Although Part D plans' benefit designs vary, they all include the following in 2022:

- **Deductible** (up to $480 in 2022). This is the amount that you must pay out-of-pocket before your plan helps pay for the cost of your drugs. Some plans have a lower or no deductible.
- **Initial Coverage Level**. You pay a fixed copay of up to 25% of drug costs up to $4,430 (in 2022) in total drug costs. (Total drug costs include both the amount you pay and the amount the plan pays for your drug.)
- **Coverage Gap**. After you have reached $4,430 (in 2022) in total drug costs, you typically pay 25% of the cost of both brand name and generic drugs (plus a nominal pharmacy dispensing fee), until **you** have incurred $7,050 (in 2022) in True Out-of-Pocket (TrOOP)

costs. This includes the deductible (if any) plus any co-payments or coinsurance paid before reaching the coverage gap, most of the cost of brand name drugs purchased in the coverage gap, and the out-of-pocket costs for generic drugs purchased in the coverage gap.

- **Catastrophic Coverage.** After you have incurred $7,050 in TrOOP (in 2022) you pay 5% of drug costs or a fixed copay of $3.95 for generic medications and $9.85 for brand-name drugs (in 2022), whichever is greater.

Enrollment in Medicare Part D

Enrollment in Medicare prescription drug coverage involves choosing either a Part D Plan (PDP) that works with Original Medicare, or a Medicare Advantage plan with prescription drug coverage (MA-PD). You can compare plans on www.medicare.gov or by calling 1-800-MEDICARE. You may also contact HIICAP for assistance.

You can enroll in Part D during your seven-month Initial Enrollment Period (IEP), (see page 6). In addition, you can join or change plans once each year between October 15 and December 7, during the Annual Election Period (AEP), to be effective January 1.

In a limited set of circumstances, a beneficiary may also be entitled to a **Special Enrollment Period (SEP)** to enroll in a Part D plan or to switch plans outside of the AEP. These include the following situations:

- Individuals with Extra Help/LIS can switch plans once per calendar quarter during the first nine months of the year (January – March; April – June; July – September), with the change effective the first of the following month.
- EPIC members can change Part D plans once per calendar year (see page 35) in addition to the AEP.
- Between January 1 – March 31, individuals enrolled in a Medicare Advantage plan (with or without Part D), can change either to a different Medicare Advantage plan (with or without Part D), or to Original Medicare with or without Part D drug coverage.
- Individuals who have a permanent change in residence, including those who move to another county where they have new Part D plan choices available, those returning to the USA after living abroad and those released from prison, can enroll in a Part D plan or switch plans.
- Individuals moving into, currently residing in, or leaving a long-term care facility, including a skilled nursing facility can enroll in a Part D plan or switch plans.
- Individuals disenrolling from employer/union-sponsored coverage, including COBRA, can enroll in a Part D plan.
- Individuals enrolled in a prescription drug plan that is withdrawing from their service area can switch to a new one.

You can apply to join a Medicare Part D plan in several ways:

- Online at www.medicare.gov or the plan's website.
- Over the telephone by calling 1-800-MEDICARE or by calling the plan directly.
- In person, through a Part D plan's representative, during a scheduled home visit.

Late Enrollment Penalty

- Even Medicare beneficiaries who do not currently use a lot of prescription drugs should consider purchasing a Part D plan. If they do not have creditable drug coverage (coverage that is at least as good as the standard Medicare prescription drug coverage), they will have to pay a late enrollment penalty if they choose to enroll later. The penalty is equivalent to 1% of the "national base beneficiary premium" ($33.37 in 2022) for each full month since first becoming eligible that these beneficiaries were not enrolled in a Medicare prescription drug plan and did not have creditable coverage. They must pay this penalty for as long as they have Part D coverage. If they have had creditable coverage and the gap between when that coverage ended and the Medicare Part D coverage begins amounts to no more than 63 days, they will not be subject to a penalty. There is no late enrollment penalty for people with full or partial Extra Help (see page 33).
- Those who enroll in Part D during their Initial Enrollment Period (IEP) will not incur a late enrollment penalty. Nor will people with creditable coverage, such as through a former employer or union, the Veterans Administration (VA), or TRICARE.

Do I need a Part D plan if I have employer health coverage?

You may not need to enroll in a Part D plan if you have creditable drug coverage (drug coverage that is at least as good as the standard Part D drug benefit) through a current or former employer. The current or former employer should advise you in writing, as to whether your drug coverage is "creditable". If it is creditable drug coverage, you may not want to also enroll in a Part D plan, because that may jeopardize your employer/retiree drug coverage and even other retiree benefits. If you do not receive a letter, contact the employer to determine if you should enroll in a Part D plan.

Do I need a Part D plan if I don't take any medications?

Having Part D coverage is optional, but bear in mind that drug needs can change, and if yours do, unless you qualify for a Special Enrollment Period, you will have to wait until the Annual Election Period (AEP), from October 15 through December 7 to sign up for a plan that will be effective the following January. Moreover, you may face a late enrollment penalty if you do not enroll when you are first eligible. With all that in mind, you may want to sign up for the least expensive plan.

How do I select a Part D plan?

To select a Part D plan, it is best to use the Plan Finder tool at www.medicare.gov. You can log in using your Medicare account username and password or do a general search where you do not enter identifying information.

Follow the Plan Finder prompts to correctly enter all the medications you are currently taking or expect to take in the coming year, along with the dosages and quantities needed. It is best to get a listing of your medications from your pharmacist before you start this process.

You can select multiple pharmacies that you would like to include in your search. After you have input all the information, the plan finder will allow you to select the type of plans you would like to view– either Part D plans that work with Original Medicare, or Medicare Advantage Plans. You can use various tools to filter the search results. It is important to look

at the details of each plan to understand what restrictions, if any, may apply. It is also advisable to call up the plan provider to verify the information.

When you have selected the plan that's right for you, you can enroll online or by calling Medicare (1-800-MEDICARE) or the Part D plan provider. HIICAP counselors are able to assist you with using the Plan Finder.

Cost Utilization Management Tools
To control costs, Medicare prescription drug plans employ cost utilization management tools–Tiers, Prior Authorization, Step Therapy, Quantity Limits.

- **Tiers:** Part D plans divide their formulary (list of covered medications) into levels called "tiers" and assign different co-payments or coinsurance for the different tiers. Generally, generic drugs are assigned to lower tiers and cost less than brand-name drugs covered under higher tiers. Some plans may even waive the deductible for lower tier generic drugs. In this way, they encourage the use of medications assigned to lower tiers.
- **Prior Authorization:** In some cases, before covering a medication in its formulary, a plan may require that a doctor contact it to explain the medical necessity for that drug.
- **Step Therapy**: Before paying for an expensive brand-name medication, a Part D plan may require beneficiaries to try less expensive drugs used to treat the same condition. If they have already tried the less expensive drugs, the beneficiaries should speak to their doctors about requesting an exception from the plan.
- **Quantity Limits:** For safety and cost reasons, plans may limit the quantity of drugs that they cover during a certain period. For instance, a plan may only cover up to a 30-day supply of a drug per month.

Part D Appeals
The process for a Part D appeal is the same process whether you are covered through a stand-alone Part D Plan (PDP) or a Medicare Advantage plan (MA). If a plan won't cover a drug, you think you need, or if the plan will cover the drug, but at a higher tier cost-sharing when drugs for the same condition on a lower tier are not as effective, you can:

- Speak to your prescriber to see if you could use another medication to treat your condition that the plan would cover (or would be covered at a lower tier).
- Ask the plan to grant an "exception" to cover your medication, or to cover your medication at a lower tier cost sharing.
- File an appeal by following the directions on the plan's denial notice. Pay attention to the time limit for filing appeals.

Extra Help with Drug Plan Costs for People with Limited Incomes

The Federal government subsidizes the cost of a Part D plan for Medicare beneficiaries with lower incomes and limited resources. The subsidy is paid directly to the Part D plan. The assistance is provided through the Low-Income Subsidy program (LIS), also known as Extra Help, and is administered by the Social Security Administration (SSA). People enrolled in Medicaid and/or a Medicare Savings Program (MSP) automatically receive Full Extra Help. You can also apply directly through SSA for Extra Help.

Full Extra Help is for beneficiaries with monthly incomes up to 135% of the Federal Poverty Level, and resource limits within the limits stated below. Income limits include an additional $20 income disregard per month. Resources include an additional $1,500 for individuals and $3,000 for couples for funeral or burial expenses.

Benefits of Full Extra Help:

- No monthly premium for a Part D plan, if the plan selected is a "benchmark" plan, a Basic plan whose monthly premium (up to $42.43 in 2022) is fully subsidized by Extra Help.
- No deductible.
- Reduced co-pays, depending on income. Beneficiaries with incomes up to 100% of the Federal Poverty Level will have co-pays of $1.35 (in 2022) for generic and $4.00 (in 2022) for brand name prescriptions. All others with full Extra Help will have co-pays limited to $3.95 (in 2022) for generic and $9.85 (in 2022) for brand name prescriptions.

Partial Extra Help is for beneficiaries with monthly incomes up to 150% of the Federal Poverty Level and resources within the limits stated below. Income limits include an additional $20 income disregard per month. Resources amounts include an additional $1,500 for individuals and $3,000 for couples for funeral or burial expenses.

Benefits of Partial Extra Help:

- Monthly plan premium on a sliding scale based on income.
- Deductible reduced to not more than $99.00 (in 2022).
- Reduced co-pays – the lower of 15% of drug costs and the plan's cost-sharing.

Extra Help Income and Asset Limits (2022)				
	Individual		**Married Couple**	
	Monthly Income	Assets	Monthly Income	Assets
Full Extra Help	$1,549	$9,900	$2,080	$15,600
Partial Extra Help	$1,719	$15,510	$2,309	$30,950

HIICAP counselors can help screen for eligibility for Extra Help, as can the Social Security Administration. To apply for Extra Help, call SSA at 1-800-772-1213 (1-800-325-0778 TTY), or apply online at www.socialsecurity.gov. You may apply for Extra Help at any time of the year.

Individuals with Extra Help will not be subject to a late enrollment penalty in Part D. Those with Extra Help may also change their Part D plan during the year outside the Annual Election Period (AEP). See page 31 for more information.

Some people automatically eligible for Extra Help may not already be enrolled in a Part D plan. The Limited Income Newly Eligible Transition (LINET) Program, administered by Humana, provides them with temporary (or retroactive) prescription drug coverage while

they enroll in a Part D plan. They may need documentation of Best Available Evidence (BAE) that they are eligible for Extra Help, such as a Medicaid award letter, MSP award letter, or proof of SSI. LINET can be reached at 1-800-783-1307.

NEW YORK STATE EPIC PROGRAM
(Elderly Pharmaceutical Insurance Coverage)

The Elderly Pharmaceutical Insurance Coverage program (EPIC) is New York State's prescription drug insurance program for senior citizens. If you are 65 years old or older, live in New York State, and have an income of up to $75,000 for singles/$100,000 for married couples, you may be eligible for EPIC. Most pharmacies in New York State participate in the EPIC program.

You must have Part D coverage (PDP or MA-PD) to have EPIC, but if you do not yet have Part D and enroll in EPIC, you can select a Part D plan at that time. Individuals with full Medicaid are not eligible for EPIC (those with a Medicaid spenddown may still be eligible).

EPIC works as secondary coverage to Medicare Part D to lower drug costs. EPIC members should present their Part D card and their EPIC card at the pharmacy each time they fill a prescription. After the Part D deductible is met, EPIC provides secondary coverage. EPIC also covers approved Part D excluded drugs, including prescription vitamins and cough and cold medicines.

EPIC Fee AND Deductible PLANS
There are two plans within EPIC, the Fee Plan, and the Deductible Plan. Applicants do not have a choice of which plan to join; EPIC makes this decision based on the individual's/couple's income.

EPIC's Fee Plan - is for individuals with annual incomes up to $20,000 and married couples with incomes up to $26,000. To participate in the Fee Plan, participants pay an annual fee, set on a sliding scale based on their previous year's income. Fees are billed quarterly. (EPIC waives its fees for members with full Extra Help.)

After paying the fee, participants pay the EPIC co-pay (ranging from $3 to $20) for their medications, based on their Part D plan's cost-sharing.

EPIC also pays the Part D monthly premium for Fee Plan members, up to $42.43 per month in 2022.

EPIC's Deductible Plan - is for individuals with annual incomes between $20,001 and $75,000, and married couples with incomes between $26,001 and $100,000. Participants in the Deductible Plan, pay for their prescriptions until they meet their EPIC deductible, which is based on their previous year's income. After meeting the deductible, participants pay only the EPIC co-pay. <u>There is no fee to join the deductible plan.</u>

EPIC pays the Part D monthly premium (up to $42.43 per month in 2022) for Deductible Plan members with incomes up to $23,000 single/$29,000 married. Deductible Plan members with higher incomes must pay their own Part D premiums, but their EPIC deductible will be lowered by the annual cost of a basic Part D plan ($510 in 2022).

After Deductible Plan members satisfy their deductible, all they will need to pay is the EPIC co-payment for covered drugs, based on their Part D plan's copays. Drug costs incurred in the Part D deductible phase are NOT applied to the EPIC deductible.

TIPS

- ✓ EPIC members without Extra Help may want to look into a Part D plan with a lower or no deductible because EPIC does not cover prescription medications purchased during a Part D plan's deductible period.
- ✓ EPIC enrollment and EPIC copays are not reflected in the www.medicare.gov Plan Finder tool.

How does EPIC work with Medicare Part D?

New York law requires EPIC members to also be enrolled in a Medicare Part D plan (see Medicare Part D, page 30), so anyone who cannot enroll in Part D for whatever reason, is not eligible for EPIC.

You can enroll in EPIC at any time of the year. If you do not have a Part D plan at the time of EPIC enrollment, you can enroll in a Part D plan afterwards.

Part D coverage is primary and EPIC coverage is always secondary. The EPIC co-pay is based on the amount remaining after an enrollee's Part D plan pays, thus reducing the enrollee's costs. For example, if you are responsible for paying a $20 co-pay for a drug using your Part D coverage and have EPIC, you would pay the EPIC co-pay on a $20 drug, which is $7. EPIC will cover you after you have met your Part D deductible, including during the initial coverage level, the coverage gap, and during catastrophic coverage, if the drugs are first covered by your Part D plan. EPIC will be a secondary payer for Part D plan members who use EPIC participating pharmacies, including most retail pharmacies in New York State, and some mail order pharmacies.

EPIC is New York State's State Pharmaceutical Assistance Program (SPAP). SPAP members have a Special Enrollment Period (SEP), that allows participants to enroll in or switch Part D plans (either a Medicare Advantage plan with Part D coverage, or a Part D plan that works with Original Medicare) one time each year in addition to the AEP.

EPIC and Extra Help

EPIC requires members who appear to be income eligible for Extra Help to provide additional information on their current income and assets/resources so that EPIC can apply to the Social Security Administration for Extra Help on their behalf. The application for Extra Help will then be forwarded to New York State's Medicaid program to assess eligibility for a Medicare Savings Program (see page 38) to help pay for their Medicare Part B premium.

Co-payments for drugs covered by Medicare Part D and EPIC:

Prescription Cost (After submitting to Medicare Part D plan)	EPIC Co-Payment
Up to $ 15	$ 3
$ 15.01 to $ 35	$ 7
$ 35.01 to $ 55	$ 15
Over $ 55	$ 20

EPIC and Employer/Retiree Drug Coverage

EPIC requires Part D plan enrollment; individuals with employer/retiree drug coverage are unlikely to have EPIC, since enrollment in a Part D plan would most likely compromise their employer/retiree coverage. However, sometimes the employer/retiree drug coverage is considered to be a Part D plan, in which case the individual could also have EPIC. **Check with the benefits manager to find out what drug coverage you have.**

Applying for EPIC

- Call EPIC at 1-800-332-3742 (TTY: 1-800-290-9138) to request an application.
- Visit https://www.health.ny.gov/health_care/epic/ for more information on EPIC You can also submit an online request for EPIC to mail you an application.
- Fillable EPIC application available at this link. Must still print. Sign and fax or mail to EPIC for processing. https://www.health.ny.gov/forms/doh-5080-fillin.pdf
- Fax the completed EPIC application to 518-452-3576, or mail it to EPIC, P.O. Box 15018, Albany, NY 12212-5018.

MEDICARE SAVINGS PROGRAMS

Medicare Savings Programs (MSPs) can help eligible individuals pay their Medicare premiums and other costs associated with Medicare. In New York City, MSPs are administered by the Human Resources Administration (HRA). You can apply for an MSP at any time of the year. MSPs are authorized for 12-months; HRA mails renewal packets annually to assess ongoing eligibility.

Below are descriptions of the different Medicare Savings Programs, followed by their income limits, and how to apply.

- **Qualified Medicare Beneficiary Program (QMB):** This program can pay for the Medicare Part A and/or Part B premium, as well as eliminate the coinsurance and deductibles for Parts A and B. An individual can be eligible for QMB only, or for QMB as well as Medicaid.
    - QMB status is noted on the Medicare Summary Notice, making it clear that the QMB beneficiary is not responsible for any Medicare cost-sharing.
    - SSI recipients when they become Medicare eligible, should be auto enrolled in QMB and in both Medicare Part A and Part B.
- **Specified Low Income Medicare Beneficiary Program (SLMB):** This program pays for the Medicare Part B premium. Individuals can receive SLMB only, or for SLMB and Medicaid (with a spenddown). The applicant must have Medicare Part A in order to be eligible for SLMB.
- **Qualified Individual (QI):** This program pays for the Medicare Part B premium. Individuals cannot receive both QI and Medicaid. The applicant must have Medicare Part A to be eligible for QI.

Medicare Savings Program 2022	Monthly Income	
	Individual	Couple
QMB - Qualified Medicare Beneficiary NY State pays premiums, deductibles, and co- insurance for those who are automatically eligible for Part A.	$1,153	$1,546
SLMB - Specified Low-Income Medicare Beneficiary Levels State pays Medicare Part B premium only.	$1,379	$1,851
QI - Qualifying Individuals State pays Medicare Part B premium only.	$1,549	$2,080

Note: Amounts listed above include a standard $20 income disregard.

Applying for a Medicare Savings Program

- You can apply for an MSP through a facilitated enroller, deputized agent, at the local Medicaid office, or by mail/fax.
    - Visit https://www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf or call 347-396-4705 to locate a Facilitated Enroller who can assist you in completing the application.
    - A deputized agent will assist you with completing the application and collecting the necessary supporting documents. To make an appointment with a deputized HIICAP counselor, call Aging Connect at 212-AGING-NYC (212-244-6469) and ask for HIICAP. You can also reach out to the Medicare Rights Center at 1-800-333-4114.
    - Mail the completed application and copies of supporting documents to: Medical Assistance Program; MSP-CREP, 5th Floor; P.O. Box 24330; Brooklyn, NY 11202-9801, or during the Public Health Emergency (PHE), you can also fax your application to: 917-639-0732.

What application do I use?

- If you are applying for an MSP only (not Medicaid and an MSP), you can use the simplified Medicare Savings Application, DOH-4328, downloadable at https://www.health.ny.gov/forms/doh-4328.pdf.
- If you are applying for both an MSP and Medicaid, you must use the Medicare Savings Application and the Access NY Health Care application, DOH-4220 found at https://www.health.ny.gov/forms/doh-4220.pdf.

What counts as income when applying for an MSP?

- Income includes wages from an employer or self-employment. It also includes funds that are received monthly, such as Social Security, pension, veteran's benefits, unemployment insurance, etc., as well as regular distributions from an IRA, 401K, 403B, or other retirement account.
- There are certain income disregards that can reduce the amount of money that is counted when determining MSP eligibility. These include paid health insurance premiums, for example: premiums for Medigap, Long Term Care Insurance, retiree health insurance, and dental or vision insurance plans.
  Note: The MSP program requires that you be collecting any Social Security benefits for which you are eligible unless you are delaying Social Security because you are working full time. (This requirement has been temporarily suspended during the Public Health Emergency).

Medicare Savings Program advocacy tips:

- Individuals in an MSP are automatically eligible for full Extra Help to lower their Medicare Part D drug costs (see page 33).
- If you apply for Extra Help through the Social Security Administration, SSA will forward your information to New York State for you to be considered for MSP eligibility.
- You may qualify for a Medicare Savings Program even if you are still working because of the earned income disregards. Less than half of income from work is counted for MSP eligibility.

MEDICARE FRAUD AND ABUSE

The federal government estimates that billions of dollars--approximately 10% of the Medicare dollars spent--are lost through fraud, waste, and abuse. Medicare beneficiaries are encouraged to be alert to, and report, any suspicious billing charges.

What is <u>fraud</u>?

Fraud is the act of obtaining, or attempting to obtain, services or payments by fraudulent means—intentionally, willingly and with full knowledge of your actions. Examples of fraud are:

- Kickbacks, bribes, or rebates.
- Using another person's Medicare card or number to obtain services.
- Billing for items or services not actually provided.
- Billing twice for the same service on the same date or a different date.
- Billing for non-covered services, such as dental care, routine foot care, hearing services, routine eye exams, etc. and disguising them as covered services.
- Billing both Medicare and another insurer, or Medicare and the patient, in a deliberate attempt to receive payment twice.

What is <u>abuse</u>?

Abuse can be incidents and practices that while not fraudulent, can result in losses to the Medicare program. Examples of abuse are:

- Over-utilization of medical and health care services.
- Improper billing practices.
- Increasing charges for Medicare beneficiaries but not for other patients.
- Not adjusting accounts when errors are found.
- Routinely waiving the Medicare Part B deductible and 20% co-insurance.

<u>Medicare do's and don'ts</u>

- Never give your Medicare number to people you don't know. File a report with Medicare if you think someone has stolen your Medicare Beneficiary Identifier (MBI).
- Beware of private health plans, doctors and suppliers who use unsolicited telephone calls or door-to-door canvassing to sell you goods and services.
- Be suspicious of people who call and identify themselves as being from Medicare. Medicare does not call beneficiaries and does not make house calls.
- Be alert to companies that offer free giveaways in exchange for your Medicare number.
- Watch out for home health care providers that offer non-medical transportation or housekeeping as Medicare-approved services.
- Be suspicious of people who claim to know ways to get Medicare to pay for a service that is not covered.
- Keep a record of your doctor visits and the processing of your bills by comparing the Medicare Summary Notice (MSN) and notices from other insurance with the actual care.

Be alert to:

- Duplicate payments for the same service.
- Services that you do not recall receiving.
- Billing for services that are different from the services received.
- Medicare payment for a service for which you already paid the provider.

How to report Medicare fraud

If you believe health care fraud or abuse has been committed, call 1-800-333-4374. Provide as much of the following information as possible:

- Provider or company name and any identifying number next to his or her name.
- Your name, address, and telephone number.
- Date of service.
- Type of service or item claimed.
- Amount approved and paid by Medicare.
- Date of the Medicare Summary Notice (MSN).
- A brief statement outlining the problem. Try to be as specific as possible.

When you assist the Medicare program in uncovering fraudulent or abusive practices, you are saving Medicare —and yourself—money.

To report Medicare Fraud and Abuse,
Call SMP (Senior Medicare Patrol) at 1-800-333-4374.

To report Medicare Part D Plan Fraud & Abuse, call the Medicare Drug Integrity Contractor
(MEDIC)_ at 1-877-7SafeRx/ 1-877-772-3379.

Fraud and Abuse Are Everyone's Problems and Everyone Can Help!

IDENTITY THEFT

The Federal Trade Commission offers information about how to protect your identity. Please contact the FTC for information or to make a complaint by calling 1-877-438-4338 or visiting www.consumer.gov/scams.

Please protect your Medicare number and Social Security number, as well as your date of birth, and any other personal information such as banking or credit card information. Be scrupulous and ask questions of those requesting this information from you and do not hesitate to inquire about the legitimacy of their need for this information. Be an informed and proactive consumer.

MEDICAID ELIGIBILITY FOR 65+, BLIND, OR DISABLED
Non-MAGI Medicaid

Medicaid is a joint federal, state, and city government health insurance program for low-income individuals. Medicaid is a "means tested" program, requiring applicants to prove financial need to be eligible. Individuals determined to be Medicaid eligible are issued a permanent plastic Medicaid card that is valid if they remain eligible. In addition to the financial guidelines, Medicaid requires that applicants be U.S. citizens or qualified aliens. Individuals applying for Medicaid in NYC must reside in NYC.

MEDICAID COVERS

- Emergency & Hospital Services
- Preventive Services
- Personal Care Services
- Case Management Services
- Approved Prescription Medication
- Physical Therapy
- Speech and Hearing Rehabilitation
- Tuberculosis (TB)-Related Services
- Mental Health Services
- Private Duty Nursing
- Hearing Aids
- Diagnostic Services
- Occupational Services
- Clinic Services
- Screening Services
- Rehabilitative Services
- Hospice Care
- Eyeglasses & Optometry Services
- Dental Services and Dentures
- Prosthetic Devices
- Transportation
- Home Health Care

Where and how you apply for Medicaid depends on your "category": those 65+, blind, or disabled apply through the NYC Human Resources Administration (HRA); those under 65 and not blind or disabled apply through the NY State of Health (NYSoH). This section discusses how individuals 65+, blind, or disabled apply for Medicaid. See page 47 for information on Medicaid for those who are under 65 and not blind or disabled.

Individuals 65+, blind, or disabled, can qualify for Medicaid in different ways, depending on what services they are requesting.

- **Community Medicaid** is health insurance coverage used by people living in their homes.
- **Institutional Medicaid** provides the full range of health coverage AND pays for care in a nursing home for full-time residents. (This is different from care in a skilled nursing facility, which is temporary and covered by Medicare Part A.)

COMMUNITY MEDICAID - eligibility requirements include a **maximum monthly income** in 2022 of $934 for single individuals/$1,367 for married couples, and an **asset** limit of $16,800 (plus $1,500 in a burial fund) for single individuals/$24,600 (plus $3,000 in burial funds) for married couples.

Medicaid counts **income** from all sources, including wages and Social Security and pension payments. There are certain allowable **income deductions**, so even if your income is over these amounts, you are encouraged to apply. Additionally, if your income is over these amounts, you may be eligible to participate in Medicaid's **Excess Income Program, also known as Medicaid Spenddown**. With the Spenddown Program, you can either pay Medicaid

your excess amount - the amount by which you are over Medicaid's income limit – or submit bills for health care expenses that add up to that amount. Meeting the spenddown either way entitles you to full Medicaid coverage for the remainder of the month.

Assets - include cash, bank accounts, retirement accounts and stocks. Certain assets are not counted toward these limits, including your primary home, your automobile and personal belongings. Community Medicaid applicants must document assets in the month of application; **there is no lookback period for transfer of assets for Community Medicaid, with the exception of those applying for community-based long-term care services.** For community-based Medicaid covered long term care services, NYS will be implementing a 30-month lookback period to be phased in over time, beginning with transfers made on or after October 1, 2020. The implementation of the lookback has been delayed until at least July 2022. The lookback will apply to new applications for home care services; those already enrolled will not have any lookback on asset transfers. Applicants seeking coverage for community-based long-term care filed before the effective date will have no lookback.

For a complete listing of how Medicaid counts income and assets, visit the Medicaid Reference Guide at www.health.ny.gov/health_care/medicaid/reference/mrg/. If your income and/or assets are over Medicaid's allowed amounts, you may want to consider applying for a Medicare Savings Program to help pay the Medicare premiums and other costs associated with Medicare (see page 38).

The Medicaid Application: Applicants complete the Access NY Health Care application, form DOH 4220, as well as Supplement A. You can access the applications and instructions at https://www.health.ny.gov/health_care/medicaid/alternative_forms.htm.

Where do I submit the application?
You have a choice of where and how to submit your Medicaid application:
Contact a Facilitated Enroller near you for assistance. Call 347-396-4705 or check www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf for a listing of enrollers.
Go to your local Medicaid office. You can get help with completing the application in person at the office or drop off a completed application. To find Medicaid offices near you, see page 55, call 311 and ask for the Human Resources Administration, or visit www1.nyc.gov/site/hra/locations/medicaid-locations.page.

Submit an application by mail. Mail the completed application along with supporting documents to:
Initial Eligibility Unit
HRA/Medical Assistance Program
PO Box 24390 Brooklyn, NY 11202-9814

You can also fax your application to 917-639-0732. Your authorized representative can fax an application to 917-639-0731.

Recertification: Medicaid is authorized for a period of 12-months. In about the 9th month of coverage, HRA mails a recertification packet in the mail that must be completed in order for ongoing eligibility to be determined.

Eliminating the Spenddown for Medicaid Applicants

Disabled individuals of any age in need of Community Medicaid services, including home care, adult day care, and prescription drug coverage, can utilize all their income to pay for living expenses by participating in a **supplemental needs trust**. Setting up a supplemental needs trust eliminates the need for individuals to contribute their "excess" or Spenddown amounts to Medicaid. A pooled-income trust fund, managed by a nonprofit agency, receives the individuals' monthly surplus income, and redistributes it on their behalf to pay expenses such as rent, utilities, etc., as they or their legal representative directs.

For more information, contact the Evelyn Frank Legal Resources Program of the NY Legal Assistance Group at 212-613-7310, or email EFLRP@NYLAG.org.

How does Medicaid work with Medicare?
It is possible to have both Medicare and Medicaid. People with both Medicare and Medicaid are known as "dual eligible." Medicare is primary coverage and Medicaid secondary. In addition to eliminating Medicare's cost-sharing requirements, such as the Part A deductible and Part B deductible and 20% co-insurance, (when they use providers that accept both Medicare and Medicaid) Medicaid in New York also offers some benefits not covered under the Medicare program, such as home health care, and dental and vision services.

Like all Medicare beneficiaries, dual eligible can choose how they receive their Medicare and Medicaid benefits. It is important to confirm with providers that they accept the coverage. Here are the different ways that dual eligible can access their Medicare and Medicaid benefits:

- Original Medicare (red, white, and blue card) + fee for service Medicaid (NYS Benefits Card) + Medicare Part D Plan.
- Special Needs Plan (SNP) specifically designed for dual eligible – SNPs are HMOs that provide all Medicare A, B and D benefits.
- Medicare Advantage Plan with Part D + fee-for-service Medicaid (NYS Benefits Card).

How does Medicaid interact with Medicare Part D?
Dual eligible are automatically enrolled in full Extra Help (see page 33) and will be automatically enrolled in a Part D plan if they do not sign up for one on their own. Dual eligible enrolled in "benchmark" Part D plans will pay no premium for Part D coverage. Dual eligible with incomes under 100% of the Federal Poverty Level (FPL) will have co-pays of $1.35 for generic/$4.00 for brand name prescriptions in 2022. Those with incomes over 100% FPL will have co-pays of $3.95 for generic /$9.85 for brand-name prescriptions in 2022.

Certain drugs, by law, are not covered by Part D, such as over-the-counter medications and vitamins. These may be covered by Medicaid with a prescription.

Medicaid Managed Long Term Care

Applying for Medicaid for personal-care services, home-care services, or private-duty nursing

Dual eligible in need of Medicaid-covered personal-care, homecare, or private-duty nursing services must first apply for Medicaid and receive Medicaid approval (with or without a Spenddown), and then follow the following steps:

Call New York Medicaid Choice/Maximus at 855-222-8350 for an evaluation of your need for home care services.

If you are approved for Medicaid covered long term care, you will be required to enroll in a Medicaid Managed Long Term Care plan. You will receive a packet in the mail informing you about your choices and how to enroll. If you don't select a plan for yourself, you will be automatically enrolled in a Managed Long Term Care plan (see first bullet below).

There are **three types** of managed long-term care plans from which to choose:

Managed Long Term Care (MLTC): MLTC plans provide primarily long-term care services. This is the most flexible of the managed long-term care plan options since enrollees continue to use their current Medicare and Medicaid plans for all services other than long-term care services.

Medicaid Advantage Plus (MAPlus): MAPlus members receive ALL their Medicaid AND Medicare services, including long-term care services, through the one plan and must use in-network providers.

Programs of All-Inclusive Care for the Elderly (PACE): PACE plan members receive all their Medicaid and Medicare services, including long-term care services. through the one plan and must use in-network providers. The PACE plans differ from MAPlus plans in that enrollee must be at least 55 years old to join PACE and PACE plans provide service through a particular site, such as a medical clinic or a hospital.

For further information on the types of managed long-term care plans, visit:
MLTC, MAP+ and PACE: https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_guide_e.pdf
Plan Directory: https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

For Medicaid applicants with an **immediate need for home care services**, there is a procedure in place to obtain Medicaid approval within 7 days, and home care approval within 12 days. Here is a link to the HRA Medicaid Alert describing the procedure: www.wnylc.com/health/afile/203/614/.

How will managed long term care work with a Medicaid Spenddown?
Many people have Medicaid with a spenddown to help them pay for Medicaid-covered home care services. These individuals pay their Medicaid spenddown to the health plan. If a member does not pay the spenddown, the plan can disenroll the member.

How do I select a plan?
Decide what type of plan would best suit your needs (MLTC, MAPlus, or PACE).
Ask your providers (home care agency, medical providers, etc.) what plans they participate in so that you can pick a plan that will allow you to continue seeing your providers. If you wish to enroll in a MAPlus or PACE plan, you also need to get your Part D drug coverage through that plan; the Plan Finder at www.medicare.gov has the prescription drug information for these plans.
To enroll in the plan, call NY Medicaid Choice at 1-888-401-6582.

How can I get help with managed long term care plans?
The Independent Consumer Advocacy Network (ICAN) is New York State's ombudsman program for people receiving long-term care services through Medicaid managed care, including MLTC, MAPlus, PACE, and mainstream Medicaid (with long-term care services). ICAN can be reached at 1-844-614-8800.

MEDICAID FOR INSTITUTIONAL CARE: Income and asset guidelines are stringent for institutional Medicaid. Generally speaking, nursing home residents have to put most of their income, except for a small monthly "personal care" allowance toward paying the nursing home costs, unless they are expected to return home. Rules are more flexible if they have a spouse still living at home.

The nursing facility should help prepare and submit the application for Institutional Medicaid. In addition to the regular Community Medicaid application, applicants must provide asset documentation for the previous 5 years. This 5-year "look-back period" allows Medicaid to identify uncompensated transfers made for purposes of becoming eligible for Medicaid.

If any such transfers are found within the 5-year look-back period, Medicaid will impose a "transfer penalty" meaning it will not pay for the applicant's nursing home stay for a period of time proportional to the amount of money transferred.

Community spouse protection: When one spouse enters a long-term care facility, the spouse remaining at home is protected from financial impoverishment due to covering the costs of care. Federal and New York State law mandate that the community spouse be allowed to retain the couple's home, car, personal belongings, and a sum of money from their joint assets.

NY STATE OF HEALTH/HEALTH INSURANCE EXCHANGE

- **Medicaid for individuals under 65, not blind or disabled**
- **Essential Plan**
- **Qualified Health Plan**

The Health Insurance Exchange is an organized marketplace for purchasing health insurance. In New York State, the exchange is known as the New York State of Health: The Official Health Plan Marketplace. There are many health insurances options available through the Marketplace in New York City. Marketplace plans offer comprehensive health coverage and have a cost sharing structures that can include premiums, deductibles, copayments, and maximum out-of-pocket costs. All plans that offer coverage through the Marketplace are HMOs, the most restrictive form of managed care. In New York City, you must select a plan that serves your borough of residence.

Under the Federal Affordable Care Act, you cannot be denied health insurance based on a pre-existing condition, those with such conditions cannot be charged more for health insurance, and there cannot be waiting periods to receive care for pre-existing conditions. These rules apply to plans purchased either through the Marketplace or outside the Marketplace.

NY State of Health evaluates eligibility for the following types of health insurance:
MAGI Medicaid, for those under 65, not blind or disabled: Income up to 138% of FPL. Can apply year-round. No resource limit.
Essential Plan: Income from 138% to 200% of FPL for those under 65. Can apply year-round. No resource limit.
"Qualified Health Plan" (QHP), with or without a federal subsidy; Can apply only during the annual open enrollment period, unless applicant has a qualifying event. No resource limit.

How to apply for coverage through the Marketplace:
Apply online at www.nystateofhealth.ny.gov.
Receive free application assistance through a navigator. Visit https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations for a listing of navigators in New York.
Call the New York State of Health Customer Service Center at 1-855-355-5777.

NY State of Health will first evaluate you for **MAGI Medicaid** eligibility. If not eligible for MAGI Medicaid, you will be evaluated for an **Essential Plan**. If not eligible for an Essential Plan, you will be evaluated for a **Qualified Health Plan (QHP)**. Some people qualify for a federal subsidy to purchase a QHP. Those not eligible for a subsidy pay the full price for the plan. You must be a citizen or a legal permanent resident residing in New York to purchase a plan through the New York Marketplace.

How does other insurance interact with Marketplace plans?
If you have non-MAGI Medicaid, you do not need to purchase other health insurance.
If you have Medicare, you do not need to purchase health insurance through the Marketplace. People with Medicare generally CANNOT enroll in a Marketplace plan. Medicare beneficiaries cannot get a federal subsidy to purchase a plan.
If you are receiving Social Security Disability Insurance (SSDI) and are in the 24-month waiting period for Medicare coverage to begin, you may want to look into a Marketplace plan. When you become Medicare eligible, you can drop your Marketplace plan. You will need to decide how to get your Medicare benefits – either Original Medicare or a Medicare Advantage plan.

MAGI MEDICAID FOR PEOPLE UNDER 65, NOT BLIND OR DISABLED

Pregnant women, children up to age 18, parents/caretaker relatives, and childless adults ages 19 through 64 are evaluated for Medicaid eligibility under MAGI (Modified Adjusted Gross Income) budgeting. Those with incomes up to 138% of FPL, estimated at $1,482 monthly for individuals/$2,004 for couples in 2022, may qualify for MAGI Medicaid. Children up to age 19 can qualify for MAGI Medicaid at higher income levels. There is no resource limit. Individuals will receive their Medicaid benefits through a managed care plan (HMO), which should be selected at the time of application. MAGI Medicaid recertification happens annually.

Individuals who are determined to be disabled, including those receiving Social Security Disability Insurance but not yet in receipt of Medicare, as well as individuals age 65 and over who are parents/caretaker relatives (even if receiving Medicare), may qualify for Medicaid at these MAGI levels.

What happens to my MAGI Medicaid through the Marketplace when I become Medicare eligible due to turning 65 or disability?[4]
Individuals with MAGI Medicaid through the Marketplace cannot maintain Marketplace coverage when they turn 65 or get Medicare due to disability, although the transition process differs in the two cases. **Exception: Parents/Caretaker relatives of minor children are allowed to maintain MAGI Medicaid through the NY State of Health and also have Medicare.** All individuals who transition from Marketplace Medicaid to Medicare will automatically receive Extra Help for Part D (see page 33).

Medicare eligible at 65: Those approaching 65 have their Medicaid case transferred to the NYC Human Resources Administration (HRA). HRA will mail forms for them to complete and return. The forms enable HRA to assess whether individuals can remain on Medicaid at the lower, non-MAGI levels. Individuals should respond to any HRA mailings if they wish to be assessed for ongoing Medicaid eligibility. HRA will give them approximately four months of Medicaid eligibility while the assessment takes place. During this time, they can use their NYS Benefits Card and access fee-for-service Medicaid from any provider who accepts Medicaid.

[4] Note: This following process has been suspended during the Public Health Emergency (PHE). Individuals who become Medicare eligible during this period maintain their MAGI Medicaid coverage.

Those collecting Social Security benefits will be automatically enrolled in Medicare at age 65. Those not collecting Social Security benefits at 65, should apply for Medicare during their 7-month Initial Enrollment Period (see page 6), since applying for Medicare is a requirement for having Medicaid if over 65.

Individuals who fail to qualify for ongoing Medicaid may want to consider joining a Medicare Advantage plan or purchasing a Medigap policy if they choose to get their benefits through Original Medicare. They will have full Extra Help (see page 33) for the remainder of the calendar year, and NY State of Health will refund the Part B premiums while they continue to have Medicaid coverage.

Individuals who are approved for ongoing Medicaid have a choice of how to receive their Medicare and Medicaid benefits.

Medicare eligible due to disability: After receiving 24 months of Social Security Disability Insurance (SSDI) payments, individuals become Medicare eligible and are automatically sent a Medicare card. They will maintain their Marketplace Medicaid coverage through the end of their 12-month Medicaid authorization period; but instead of their Medicaid HMO plan card, they will use their Medicare and Medicaid cards to access health services. Medicare is their primary health insurer, and Medicaid is their secondary insurance. As their 12-month authorization period approaches its end, their Medicaid case is transferred from NY State of Health to HRA. HRA will mail them forms to evaluate them for ongoing Medicaid eligibility. They should enroll in a Part D plan that best covers their medications; if they do not select a plan, they will be automatically enrolled in a plan.

THE ESSENTIAL PLAN

The Essential Plan is for people under age 65 with monthly incomes between 138% and -200% of FPL, estimated at up to $2,265 for individuals and $3,052 for a household of two in 2022. Those in the Essential Plan can select to enroll in a Basic Health Program and will pay either $0 or $20 in monthly premiums.

Enrollment in the Essential Plan takes place year-round.

Essential Plan enrollees who become Medicare eligible are no longer eligible for the Essential Plan. They will receive a notice from NY State of Health stating that their enrollment is ending. These individuals should enroll in Medicare A, B, and D during their 7-month Initial Enrollment Period (see page 6) and may want to consider supplemental insurance coverage.

QUALIFIED HEALTH PLANS

Qualified Heath Plans are available for anyone to purchase; those with annual incomes less than 400% of the Federal Poverty Level (estimated at $51,520 for individuals and $106,000 for a family of four in 2021), may be eligible for a federal subsidy in the form of a tax credit to help pay for the cost of a plan.

When can I enroll in a Qualified Health Plan?

Open enrollment for the Marketplace takes place annually, usually from November 1 through January 31. After January 31, you will need to wait for the next annual open enrollment period

to enroll. There are certain exceptions that allow you to enroll mid-year, including losing current health insurance coverage.

There are several ways to learn more about Marketplace plans:
Reach out to a "Navigator." Navigators are organizations in your community that can help you select and enroll in a plan. To find a navigator near you, go to https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations or call the Community Health Advocates at 1-888-614-5400.
Contact New York State of Health, operated by Maximus, at 1-855-355-5777, Monday-Friday, 8 am–5 pm.
Visit nystateofhealth.ny.gov.

People with a QHP (Marketplace plan) who become eligible for Medicare are generally advised to enroll in Medicare when first eligible and drop their QHP by notifying their plan This is because:

- One cannot continue to get any premium subsidy or cost sharing reduction (to help pay for the QHP premium) after becoming Medicare eligible.
- Having a QHP does not extend their time to enroll in Medicare. Late enrollment could mean a gap in coverage and a late enrollment penalty.

Beneficiaries are responsible for enrolling in Medicare A, B and D during their Initial Enrollment Period (see page 6 for more information) and for dropping QHP coverage.

People who may want to carefully consider QHP versus Medicare are those who:

- Do not qualify for premium free Part A. They may get a premium subsidy or cost sharing reduction for QHP coverage, but only if they don't enroll in Part A or B. Should they wish to enroll in Medicare at a later time, they would have a delay, as well as a late enrollment penalty, for both Medicare A and B.
- Are under age 65 and have End Stage Renal Disease.

VETERANS' BENEFITS AND TRICARE FOR LIFE

To receive health care at facilities operated by the Department of Veterans Affairs (VA), veterans must be enrolled with the VA. Veterans can apply for coverage at any time.

Enrolled Veterans do not need to submit their income information. However, certain veterans will be asked to complete a financial assessment to determine their eligibility for free medical care, medications and/or travel benefits.

Effective 2015, VA eliminated the use of net worth as a determining factor for both health care programs and copayment responsibilities. VA now only considers a Veteran's gross household income and deductible expenses from the previous year. Certain lower-income, non-service-connected veterans will have less out-of- pocket costs. To learn more, visit www.va.gov/healthbenefits/apps/explorer/AnnualIncomeLimits/HealthBenefits.

Veterans not eligible for free care are responsible for a co-payment.

The VA cannot bill Medicare, so veterans with Medicare only who are responsible for the co-pay for medical care will be billed the appropriate charge for services. However, if they have a supplemental policy, the VA will bill the supplemental insurer first.
In some circumstances, the VA may pre-authorize services in a non-VA hospital or other care setting. Veterans may need to pay a VA copayment for non-service-connected care. If not, all services are authorized to be covered by the VA, then Medicare may pay for other services the veteran patients may need during their stay.

How do VA benefits interact with Medicare Part A and Part B?
Medicare Part A and Part B work independently from the VA health system. For this reason, those eligible for Medicare may want to enroll to use hospitals and providers outside the VA health care system. If they don't enroll in Medicare when first eligible, and are not eligible for a Special Enrollment Period, they may be responsible for a Part B late enrollment penalty.

How does VA drug coverage interact with Medicare Part D?
VA coverage for prescription drugs is considered creditable, meaning it is as good as, or better than, Medicare Part D. It is possible to have both a Part D plan and VA drug coverage. Those choosing to forego Part D who later wish to enroll in Part D, will not be subject to a penalty for late enrollment. However, they will need to wait until the annual open enrollment period (October 15 – December 7) to enroll in a plan, with coverage starting on January 1, unless they qualify for a special enrollment period.

TRICARE Health Benefits provides coverage to active-duty service members and their families, families of service members who died while on active duty, former spouses, and retirees and their families, whether or not the retirees are disabled, and National Guards/Reservist members. Military retirees (and their spouses) who have served at least 20 years, are 65 years or older and are currently enrolled in Medicare Parts A and B are eligible for TRICARE for Life (TFL). TFL is a premium-free health care plan that acts as a supplement

to Medicare and includes creditable drug coverage. For more information on TRICARE for Life call 1-866-773-0404 or visit www.tricare.mil.

Civilian Health and Medical Program (CHAMPVA) is a health insurance program for dependents of veterans with a permanent and total service-connected disability. Most Medicare and TRICARE providers will also accept CHAMPVA (but be sure to ask the provider). Those eligible for TRICARE cannot be enrolled in CHAMPVA. For more information on CHAMPVA, call the VA at 1-800-733-8387 or visit www.va.gov

For more information on health VA benefits, call 1-877-222-8387 (open 7am to 7pm Central Time) or visit www.va.gov.

OTHER HEALTH COVERAGE OPTIONS FOR NEW YORKERS

COBRA

Federal law requires employers with 20 or more employees to offer employees who leave their job COBRA as a "continuation" of employer-based health care coverage. In New York State, most people can get COBRA coverage for up to 36 months. COBRA can bridge the gap until you go on Medicare or take a new job that offers health insurance. You can qualify for coverage if you retire, leave your job, get laid off, have your work hours cut, or lose your coverage through an actively working spouse as a result of death or divorce. Your spouse and dependents are also entitled to benefit from your COBRA coverage.

If you are on COBRA before you become Medicare eligible, COBRA generally stops when Medicare starts. If you are already eligible for Medicare and still working, you may elect COBRA when you stop working. If you have both Medicare and COBRA, Medicare is primary, and COBRA is secondary. COBRA coverage does not allow someone to delay enrollment in Part B without penalty, even if the cost of COBRA is being subsidized by a former employer.

HHC Options

HHC Options is a NYC Health + Hospitals (HHC) program that enables low- and moderate-income individuals and families to access health care through HHC's network of hospitals and health facilities on a sliding fee scale. There is no charge to participate in HHC Options; you pay when you access care. HHC does not look at immigration status when determining eligibility. For more information, visit
https://www.nychealthandhospitals.org/paying-for-your-health-care/financial-assistance/
or call 1-844-692-4692.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC) are comprehensive health centers that can provide primary care, mental health and substance abuse treatment, dental care, and prescription drugs to people of all ages. Although FQHCs accept health insurance, they also see patients with no insurance on a sliding-fee scale, charging patients according to their income. For eligible Medicare beneficiaries, FQHCs can waive the annual Part B deductible and the 20% co-insurance. To locate a FQHC, visit https://findahealthcenter.hrsa.gov/ .

Health Insurance & Self Employment

Some professions offer group rate insurance. Please inquire with your former employer and/or any professional associate memberships to which you belong. Here are a few potential resources.

Small Business Service Bureau	Small business employee	800-472-7199 www.sbsb.com
Graphic Artists Guild	Graphic Artists	1-212-791-3400 graphicartistsguild.org
National Writers Union	Writers	315-545-5034 www.nwu.org
Screen Actors Guild	Performers	1-212-944-1030 www.sagaftra.org
Freelancer's Union	Independent Workers	www.freelancersunion.org

MEDICARE 2022

Part A: Hospital Insurance

Deductible	$1,556 per benefit period
Co-Payment	$389 per day for days 61-90 of each benefit period
	$778 per day for each "lifetime reserve day"
Skilled Nursing Facility Co-Pay	$194.50 per day for days 21-100 of each benefit period

Part B: Medical Insurance

Monthly Premium	Most Medicare beneficiaries pay the standard premium of $170.10, except for: • Those whose Social Security Cost of Living Adjustment (COLA) didn't increase enough to raise their Part B premiums to the $170.10 level. • Higher-income (over $91,000 single/182,000 married) beneficiaries, who pay higher amounts.
Annual Deductible	$233
Coinsurance	20% for most services

Some people 65 or older do not meet the SSA requirements for **premium-free Hospital**

Insurance (Part A). If you are in this category, you can get Part A by paying a monthly premium. In 2022, if you have fewer than 30 quarters of Social Security coverage, your monthly Part A premium is $499. If you have 30 to 39 quarters of Social Security coverage, your monthly Part A premium is $274.

Medicare Savings Program 2022

	Monthly Income	
	Individual	**Couple**
QMB - Qualified Medicare Beneficiary NY State pays premiums, deductibles, and co- insurance for those who are automatically eligible for Part A.	$1,153	$1,546
SLMB - Specified Low-Income Medicare Beneficiary Levels State pays Medicare Part B premium only.	$1,379	$1,851
QI - Qualifying Individuals State pays Medicare Part B premium only.	$1,549	$2,080

Note: Amounts listed above include a standard $20 income disregard.

MEDICAID 2022

Standard Medicaid

Maximum Income and Asset Levels* for those who are blind, disabled or age 65 and over:

***The first $20 of income is exempt. Above figures are prior to the $20 disregard. You are permitted a burial fund allowance of $1,500 per person.**

	Monthly Income	**Assets**
Individual	$934	$16,800
Couple	$1,367	$24,600

Nursing Home-Based Medicaid

INCOME - When a nursing home resident qualifies for Medicaid support, all income goes to the nursing home except for $50 monthly allowance for the resident's personal needs.

ASSETS - All personal assets must be used up first to meet costs (excluding primary residence, automobile, and personal possessions).

MARRIED COUPLES - When one spouse qualifies for Medicaid support in a nursing home, the community spouse (the one remaining at home) is entitled to retain some income and resources belonging to the couple while Medicaid pays toward the residential spousal care.

The community spouse is allowed to retain the following	
Resources	$74,820 minimum; $137,400 maximum
Income:	$3,435 monthly
For more information on Medicaid, call HRA's Medicaid Helpline at **1-888-692-6116**	

Medicaid Offices in New York City

Medicaid applicants can call the Medicaid Helpline at **1-888-692-6116** to find the nearest Medicaid office, office hours, and directions. New York City residents can apply at any office in the five boroughs.

NOTE: Although most Medicaid offices have re-opened following the COVID-19 Public Health Emergency, people are encouraged to only visit an office if they cannot be assisted via phone.

Bronx	**Fordham**: 2541-2549 Bainbridge Ave. (929) 252-3230 **Rider**: 305 Rider Avenue, 4th Floor. (718) 585-7872
Brooklyn	**Coney Island**: 3050 West 21st Street, 3rd Floor. (929) 221-3790 **East New York**: 404 Pine Street, 2nd floor. 929-221-8204 **Kings County Hospital**: 441 Clarkson Avenue, "T" Building, Nurses Residence, 1st Floor. (718) 221-2300 ext. 2301 (closed until further notice) **Brooklyn South (Central Medicaid Office)**: 785 Atlantic Avenue, 1st Floor. (929) 221-3502
Manhattan	Chinatown: 115 Chrystie Street, 5 floor. (212) 334-6114 Dyckman Community: 4055 10th Avenue Lower Level (212) 939-0207 ext. 0208
Queens	**Queens Community**: 32-20 Northern Blvd., 3rd Floor. (718) 784-6729 **Jamaica**: 165-08 88th Avenue, 8th Floor. 929-252-3193
Staten Island	**Staten Island**: 215 Bay Street. (929) 221-8823/8824

Medicare Part B and Part D Income-Related Monthly Adjustment Amount (IRMAA) for Higher Income Medicare Beneficiaries in 2022

2020 Modified Adjusted Gross Income (MAGI)	Part B Monthly Premium	Part D (Prescription Drug) Monthly Premium
Individuals with a MAGI of $91,000 or **less**/ Married couples with a MAGI of $182,000 or **less**	2022 Standard Premium = $170.10	Your Plan Premium
Individuals with a MAGI $91,000–$114,000/ Married couples with a MAGI $182,000–$228,000	$238.10	Your Plan Premium + $12.40
Individuals with a MAGI $114,000–$142,000/ Married couples with a MAGI $228,000–$284,000	$340.20	Your Plan Premium + $32.10
Individuals with a MAGI $142,000–$170,000/ Married couples with a MAGI $284,000–$340,000	$442.30	Your Plan Premium + $51.70
Individuals with a MAGI $170,000–$500,000/ Married couples with a MAGI $340,000–$750,000	$544.30	Your Plan Premium +$71.30
Individuals with a MAGI greater than $500,000/ Married couples with a MAGI greater than $750,000	$578.30	Your Plan Premium +$77.90
Married filing separately with a MAGI less than $91,000	$170.10	Your plan premium
Married filing separately with a MAGI $91,000–$409,000	$544.30	Your Plan Premium +$71.30
Married filing separately with a MAGI $409,000 and greater	$578.30	Your Plan Premium $77.90

- Modified Adjusted Gross Income is equal to adjusted gross income + tax exempt interest income
- The Part B Premium and IRMAA for Part B and Part D are deducted from your Social Security benefit (or billed if you are not collecting Social Security benefits).
- The Part D surcharge is deducted from your Social Security check (or billed, if you are not collecting Social Security benefits), even if you pay your Part D premium directly to the plan.

Health Insurance Definitions

Brand-Name Drug	A drug that has a trade name and is protected by a patent. It can be produced and sold only be the company holding the patent.
Coinsurance	An amount that you must pay for medical care. It is a percentage of the total cost of care.
Copayment	A fixed dollar amount that you pay for a medical service.
Creditable Coverage	Prescription drug coverage that is as good as, or better than, a basic Medicare Part D drug plan.
Deductible	An amount that you must pay each year before an insurance policy starts paying.
Dual Eligible	Someone with both Medicare and Medicaid.
Federal Poverty Level (FPL)	A measure of income issued every year by the federal government. The amounts are used to determine eligibility for certain programs and benefits.
Formulary	A list of drugs covered by a prescription drug plan.
Generic Drug	A drug that has the same active ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs.
Income-Related Monthly Adjustment Amounts (IRMAA)	Higher Medicare Part B and Part D premium payments required of people with higher incomes.
Pre-existing Condition	A health disorder that existed before the date your insurance coverage became effective.
Premium	The amount that you pay for having an insurance policy. You pay the premium regardless of whether you use any health services.
Prior Authorization	Approval that must be obtained beforehand in order for an insurance company to cover a medication or service.
Quantity Limits	A limit on the amount of a prescription medication that a Part D drug plan will cover during a certain period of time for safety and/or cost reasons.
Step Therapy	A restriction a Part D drug plan imposes, requiring you to first try one drug for a certain condition before it will cover another drug for that condition.

Resources for Assistance in Paying for Prescription Medications

(Each program has its own eligibility requirements. Call or check the website for additional qualifying information and how to apply.)

ADAP (AIDS Drug Assistance Program) - Provides free medications for the treatment of HIV/AIDS and opportunistic infections. ADAP can help people with partial insurance, including Medicare Part D, and those who have a Medicaid spenddown requirement. Call (800) 542-2437 or visit www.health.ny.gov/diseases/aids/general/resources/adap/eligibility.htm for more information.

Benefits Check Up – Helps people locate benefits and services available to them. www.benefitscheckup.org

BigAppleRx Prescription Drug Discount Card A free NYC-sponsored discount card. Anyone can get the card, regardless of age, income, citizenship, and health insurance status. The discount can be applied to both brand and generic medications. Visit www.BigAppleRx.com or call 1-888-454-5602 for more information.

CancerCare Co-Payment Assistance Foundation Helps individuals with cancer with copayments for their prescribed treatments. Visit www.cancercarecopay.org, or call 1-866-552-6729.

Good Days Helps people with certain chronic diseases with their insurance copays. For more information, and a list of qualifying diseases and medications, visit www.mygooddays.org, or call 1-877-968-7233.

GoodRx Allows you to compare the cost of drugs at different pharmacies. You can search for discounts and print coupons. Visit GoodRx.com for more information.

HealthWell Foundation Provides financial assistance to eligible individuals to cover coinsurance, copayments, health care premiums, and deductibles for patients with certain diseases. Visit Healthwellfoundation.org or call 1-800-675-8416.

Leukemia and Lymphoma Society Co-Pay Assistance Program Helps with premiums and copays for both private insurance and Medicare plans. Visit https://www.lls.org/support/information-specialists, or 1-800-955-4572.

Medicine Assistance Tool Search engine for many of the patient assistance resources that the biopharmaceutical industry offers. Visit www.medicineassistancetool.org.

National Marrow Patient Assistance Program and Financial Assistance Fund - May assist eligible individuals with the cost of bone-marrow or cord-blood transplant if insurance does not cover the full cost. Visit www.bethematch.org or call 1-888-999-6743.

National Organization for Rare Disorders (NORD) - Helps uninsured or underinsured individuals with certain health conditions to access needed medications. Visit www.rarediseases.org or call 1-800-999-6673.

NeedyMeds.org Provides information on Patient Assistance Programs (PAPs). Visit www.needymeds.org or call 1-800-503-6897.

Patient Advocate Foundation Co-Pay Relief Helps eligible individuals with certain diagnoses with copayments for prescription medications. Visit www.copays.org, or call or 1-866-512-3861.

Patient Services Incorporated (Now Accessia Health) May be able to assist people with certain rare or chronic conditions with paying health insurance premiums and copayments/coinsurance, as well as costs related to travel. Visit www.patientservicesinc.org or call 1-800-366-7741.

RX Hope Enables people to apply for discounted and free medications directly through the website. Visit www.rxhope.com.

Other Internet Resources

Department of Labor Information on COBRA, Black Lung Disease, etc. www.DOL.gov

Health and Human Services Administration www.hhs.gov

HealthFinder.gov Information specific to particular health conditions

National Council on Aging www.ncoa.org

National Health Information Center www.health.gov/nhic

Resource	Phone
HIICAP Helpline – NYC Department for the Aging's Aging Connect and ask for **SHIP/HIICAP** www1.nyc.gov/site/dfta/services/health-insurance-assistance.page	1-212-AGING-NYC (212-244-6469)
Aging Connect – for services offered by the NYC Department for the Aging www.nyc.gov/aging	1-212-AGING-NYC (212-244-6469)
Access-A-Ride - http://web.mta.info/nyct/paratran/guide.htm	1-877-337-2017
Advocacy, Counseling, and Entitlement Services Project (ACES)	1-212-614-5552
Center for the Independence of the Disabled in New York www.cidny.org	1-212-674-2300 or 1-646-442-1520
Centers for Medicare and Medicaid Services (CMS) www.cms.gov	1-800-MEDICARE
Columbia University College of Dental Medicine's Teaching Clinic www.dental.columbia.edu/teaching-clinics	1-212-305-6100
Community Health Advocates www.communityhealthadvocates.org	1-888-614-5400
Eldercare Locator www.eldercare.acl.gov	1-800-677-1116
Elderly Pharmaceutical Insurance Coverage (EPIC) www.health.state.ny.us/health_care/epic/index.htm	1-800-332-3742
Health Information Tool for Empowerment (resource directory of free and low-cost health and social services) - www.HiteSite.org	1-866-370-4483
Health and Hospitals Corporation) https://www.nychealthandhospitals.org/paying-for-your-health-care/financial-assistance/	1-844-NYC-4NYC
HRA Info Line – for all HRA programs, including Food Stamps, Public Assistance and Medicaid	1-718-557-1399
HRA Medicaid Helpline	1-888-692-6116
Hospice Foundation of America - www.hospicefoundation.org	1-800-854-3402
ICAN - Independent Consumer Advocacy Network – Medicaid managed long-term care ombudsman - https://icannys.org/	1-844-614-8800
Legal Services NYC - www.legalservicesnyc.org	1-844-614-8800
Limited Income Newly Eligible Transition (LINET) Program (Administered by Humana)	1-800-783-1307

Resource	Phone
Livanta - Quality Improvement Organization (for discharge appeals and quality of care complaints)	1-866-815-5440
Medicaid facilitated enrollers for Aged, Blind and Disabled (can also help with Medicare Savings Program applications)	1-347-396-4705
Medicaid Fraud Control Unit (NY Attorney General)	1-800-771-7755
Medicare Fraud Hotline (Office of the Inspector General, DHHS)	1-800-447-8477
Medicare Hotline	1-800-MEDICARE
Medicare Rights Center www.medicarerights.org/ www.medicareinteractive.org	1-800-333-4114
New York Connects (information on long term care services and support)	1-800-342-9871
NYS Department of Health Office of Professional Medical Conduct (physician quality control complaints)	1-800-663-6114
New York Legal Assistance Group's (NYLAG) Evelyn Frank Legal Resources Program - EFLRP@NYLAG.org	1-212-613-7310
New York State of Health (Marketplace) - https://nystateofhealth.ny.gov	1-855-355-5777
NYC Department of Health - www.nyc.gov/health	311
NYS Long Term Care Ombudsman Program https://ltcombudsman.ny.gov/	1-855-582-6769
NYS Department of Health- Managed Care Plan complaints	1-800-206-8125
NYS Department of Financial Services - www.dfs.ny.gov	1-800-342-3736
NYS Medicaid Helpline	1-800-541-2831
NYS Office for the Aging Senior Citizen Helpline - www.aging.ny.gov	1-800-342-9871
NYS Office of Victim Services - https://ovs.ny.gov/help-crime-victims	1-800-247-8035
NYU Dental Clinic - www.nyu.edu/dental	1-212-998-9800
Railroad Retirement Board - www.rrb.gov	1-877-772-5772
SMP (Senior Medicare Patrol) to report Medicare fraud/abuse in NYS	1-800-333-4374
Social Security Administration - www.socialsecurity.gov	1-800-772-1213 TTY 1-800-325-0778
United States Department of Veterans Affairs - www.va.gov	1-800-827-1000

NOTES

Eric Adams

Mayor

City of New York

Lorraine Cortés- Vázquez

Commissioner

NYC Department for the Aging