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纽约市老人局

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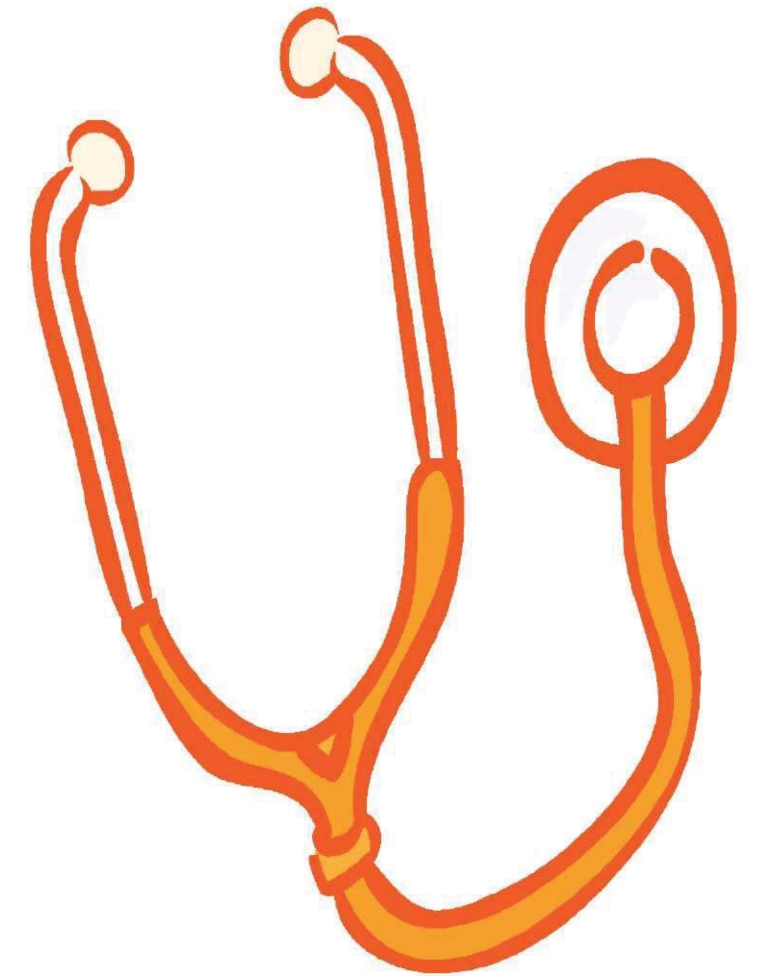
A Complete Guide to Health Insurance Coverage for Older New Yorkers

2020



紐約老年人 健康保險 完全指導手冊

2020

HIICAP

Health Insurance Information, Counseling and Assistance Program

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

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 at 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 212-244-6469 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
https://aging.ny.gov/programs/medicare-and-health-insurance

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本指導手冊是由紐約市老人局的醫療保險資訊諮詢與協助計畫 (HIICAP) 製作，以協助紐約市老年人更加瞭解紐約市目前所提供的醫療保險選項。主題包括聯邦醫療保險 (Medicare) A 部分與 B 部分、聯邦醫療保險補充保險 (Medigap)、聯邦醫療保險優勢保健計畫、聯邦醫療保險 (Medicare) D 部分、聯邦醫療保險免保費計畫 (Medicare Savings Programs)、聯邦醫療補助 (Medicaid) 及長期照護保險。此文檔中提供的是列印之時的最新資訊。請善加利用以維持良好健康！

HIICAP 為紐約市老年人提供免費、最新且公正的醫療保險資訊來源。HIICAP 專線能協助您解答疑問。請致電老人局 Aging Connect 專線：212-244-6469，並洽詢 HIICAP 與受過專業訓練的輔導人員洽談。

HIICAP 輔導員可透過電話與您洽談或在輔導處與您見面。只要致電我們的專線，請其轉介最接近您所在地點的輔導員即可。

請注意，紐約市老人局所提供的信息並不構成為這些計畫的擔保或推薦。

www.nyc.gov/aging
https://aging.ny.gov/programs/medicare-and-health-insurance

此專案已獲得美國華盛頓特區 20201 的美國社區生活管理局、健康與人類服務部之部分撥款支援，款項編號90SAPG0033。

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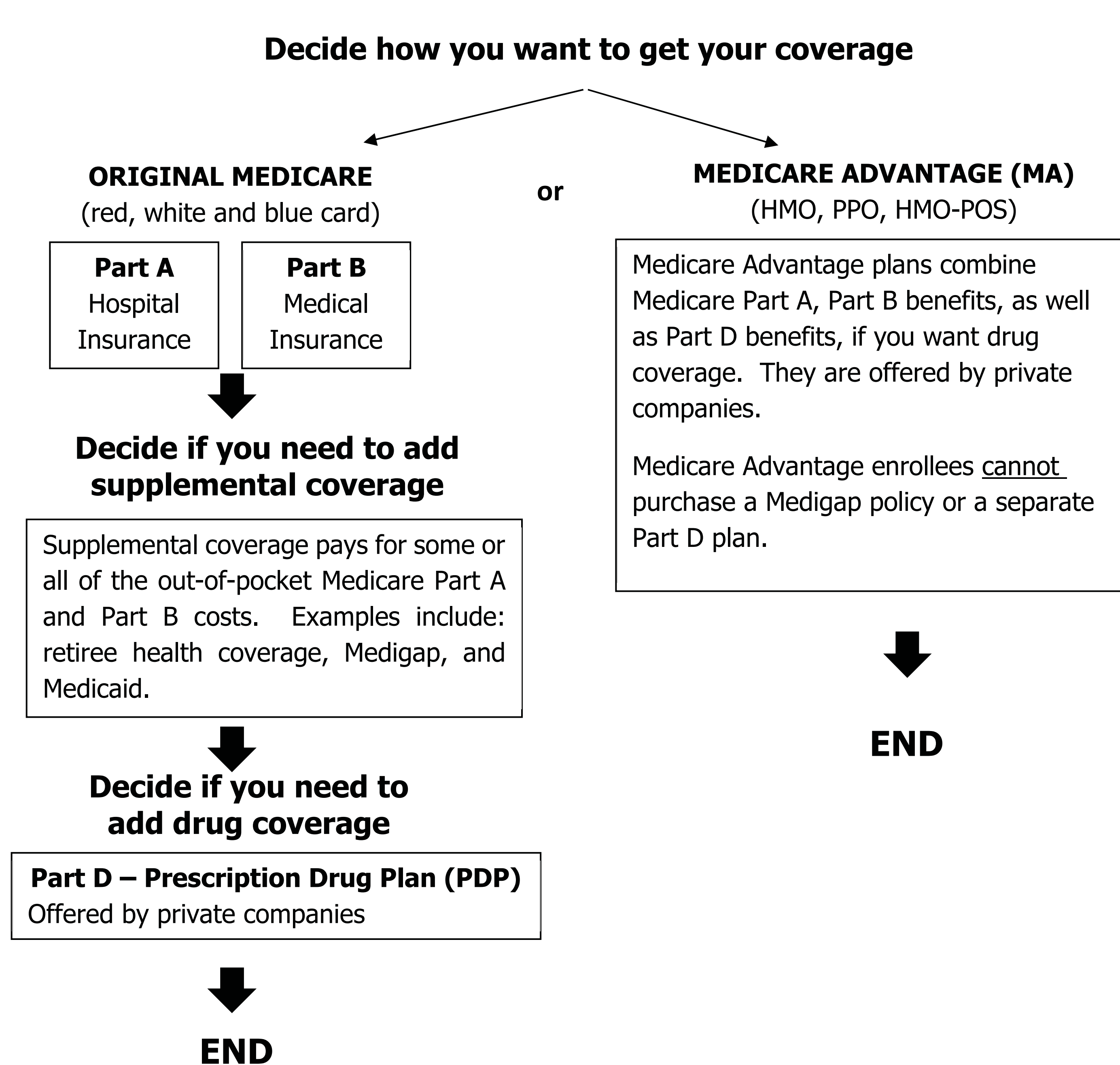
MEDICARE COVERAGE CHOICES

Everyone with Medicare has choices in how they get their Medicare coverage.

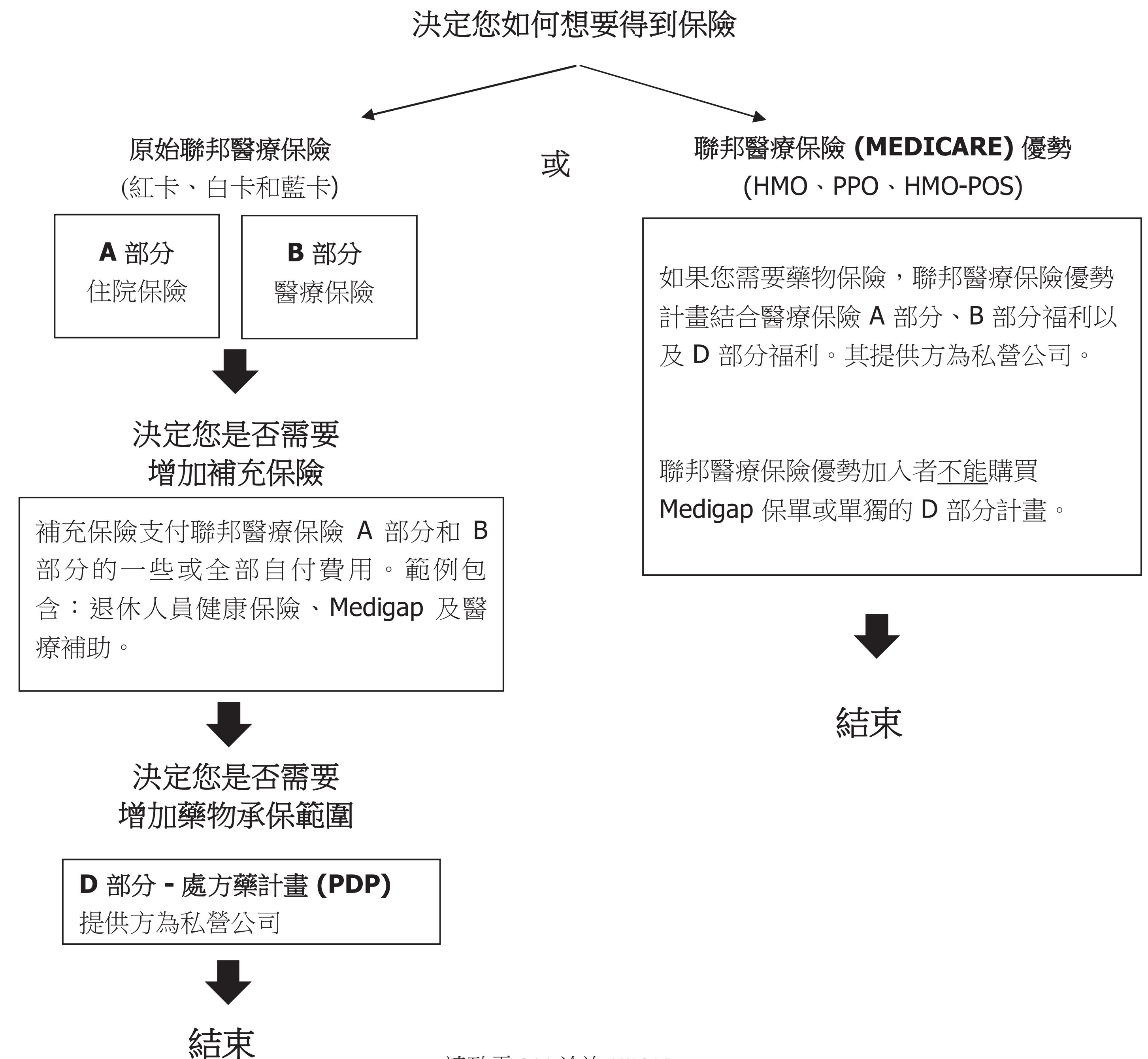
There are two main ways to get your coverage – Original Medicare or a Medicare Advantage Plan. Below is a decision tree to help guide your decision-making.



聯邦醫療保險 (MEDICARE) 保險選擇

享受聯邦醫療保險的每個人在其如何獲得保險方面所具有的選擇。

有兩種方式得到您的保險 - 原始聯邦醫療保險或聯邦醫療保險優勢計畫。下文是決策樹，幫助指導決策。



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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. If someone joins a Medicare Advantage plan, they will have Medicare coverage through that private plan, not through "Original Medicare." See page 3 for a summary chart of 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.
  - Individuals with end stage renal disease (ESRD) can qualify for Medicare, regardless of age. A worker, as well as a worker's spouse (including same-sex spouse) or children may be eligible for Medicare, based on the worker's work record, if she or he receives continuing dialysis for permanent kidney failure or had a kidney transplant, even if no one else in the family is getting Medicare.

How eligibility differs for Part A vs. Part B:
- To qualify for premium-free Part A at 65, you or your spouse (including same-sex spouse) must be insured through Social Security (by having earned 40 quarters of coverage). Without 40 quarters of coverage, one may still get Medicare by paying a premium for Part A at age 65.
- One does not need 40 quarters of coverage to qualify for Part B; one needs to 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 about applying for Medicare at www.socialsecurity.gov.

聯邦醫療保險 (MEDICARE)

聯邦醫療保險是針對 65 歲或以上老人、某些未達此年齡的殘障人士及腎臟衰竭（末期腎臟疾病，英文縮寫 ESRD）患者而設的全國性醫療保險計畫。

聯邦醫療保險 (Medicare) 的主要部分是：
- A 部分 - 住院保險
- B 部分 - 醫療保險
- D 部分 - 處方藥保險

聯邦醫療保險受益人可以選擇透過原始聯邦醫療保險，或是透過聯邦醫療保險優勢計畫（Medicare Advantage Plan，有時稱為 C 部分）獲得聯邦醫療保險權益。聯邦醫療保險優勢計畫是由民營公司管理，而且會透過管理式護理提供所有聯邦醫療保險 A 部分和 B 部分權益，以及 D 部分藥物保障。參加聯邦醫療保險優勢計畫者將經由該項私營計畫取得聯邦醫療保險，而非透過聯邦醫療保險原始計畫。請參閱第 3 頁以取得這些選擇的摘要圖表。

誰有資格申請參加聯邦醫療保險？
- 年齡:如果您年滿 65 歲或以上，即符合聯邦醫療保險 (Medicare) 的資格，並且是
  - 美國公民或
  - 連續居住 5 年的合法永久居民（如未符合社會安全資格）。
- 65 歲以下的人士可登記加入聯邦醫療保險
  - 在接受 24 個月的社會安全殘疾保險 (SSDI) 之後。肌萎縮性脊髓側索硬化症 (Amyotrophic Lateral Sclerosis, ALS) 之患者在接到 SSDI 的第一個月即符合資格。
  - 末期腎臟疾病 (ESRD) 患者皆有資格參加聯邦醫療保險 (Medicare)，不受年齡限制。勞工、以及勞工的配偶（包括同性配偶）或子女可能有資格參加聯邦醫療保險，視勞工的工作記錄而定，若其因永久性腎臟衰竭而持續接受洗腎或曾進行腎臟移植，即使家庭中無其他成員擁有聯邦醫療保險，亦得以參加。

A 部分與B 部分的資格要求有何不同：
- 若要在 65 歲時符合免保費 A 部分的資格，您或您的配偶（包含同性配偶）必須透過社會安全福利進行登記加入（已累積 40 個工作季點）。若尚未取得 40 個工作季點，個人仍可以藉由在 65 歲時支付 A 部分保費而獲得聯邦醫療保險。
- 不需取得 40 個工作季點，即可符合 B 部分；必須是美國公民或是連續居住五 (5) 年的合法永久居民。

若您對聯邦醫療保險的參加資格有疑問，或是有意申請聯邦醫療保險，請致電社會安全局 1-800-772-1213 (1-800-325-0778 聽障專線)。欲進一步瞭解如何申請聯邦醫療保險，請至網站 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.

The following people are **automatically enrolled** in Medicare when first eligible:

- 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 – which are detailed below.

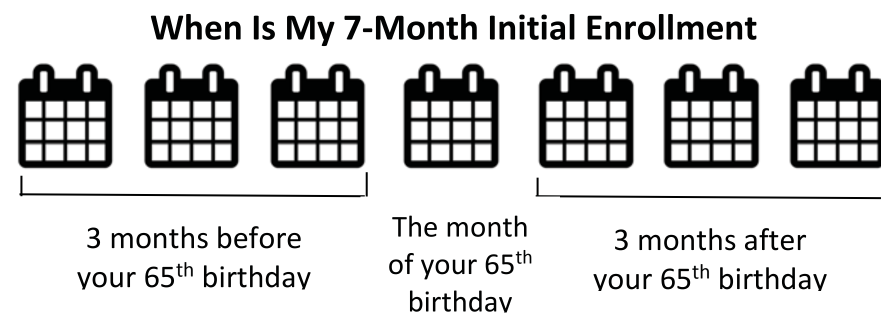
Initial Enrollment Period (IEP)

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 in Medicare. The IEP is 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.

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

When Is My 7-Month Initial Enrollment



如何加入聯邦醫療保險？

有些人會自動登記加入聯邦醫療保險，而其他人則必須主動登記加入。重要的是瞭解 A 部分及 B 部分的登記加入規定，以避免遭罰延遲登記罰金 (LEP) 及/或醫療保障產生缺口。

以下對象在符合資格時即被**自動納入**聯邦醫療保險 (Medicare)：

- 若您在年滿 65 歲時已開始領取社會安全福利金或鐵道退休福利金，則無需自行申請聯邦醫療保險。您將自動加入 A 部分和 B 部分，而且您的聯邦醫療保險卡將在您的 65 歲生日之前 3 個月寄送給您。您必須已登記加入 A 部分，才能領取社會安全福利。如果您想要拒絕聯邦醫療保險 B 部分福利，請遵循連同聯邦醫療保險卡郵寄給您的說明。
- 若您領取社會安全殘疾保險 (SSDI) 福利，在連續 24 個月領取社會安全殘障福利金之後，聯邦醫療保險卡將自動寄送給您。您必須已登記加入 A 部分，才能領取社會安全福利。如果您想要拒絕聯邦醫療保險 B 部分福利，請遵循連同聯邦醫療保險卡郵寄給您的說明。

如果您因為即將年滿 65 歲而未領取社會安全福利，而且您希望在年滿 65 歲時可以領取聯邦醫療保險福利，重要的是瞭解**三個參加期間**──首次參加期、特定參加期和一般參加期──詳列如下。

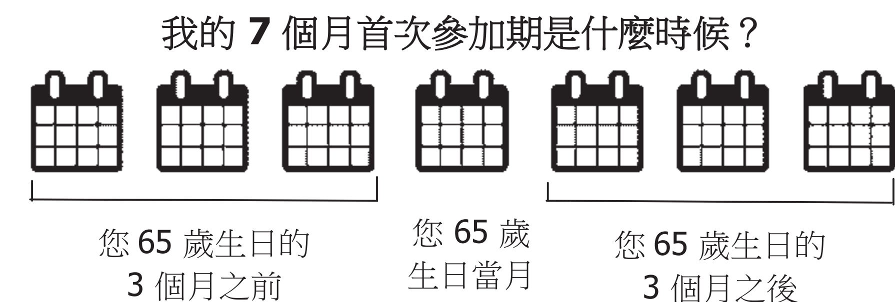
首次參加期 (IEP)

若您年滿 65 歲時尚未領取社會安全福利金，而且您希望登記加入聯邦醫療保險 B 部分，則有 7 個月的首次參加期 (IEP) 可登記加入聯邦醫療保險。IEP 是在您年滿 65 歲之前的 3 個月、您年滿 65 歲當月，以及之後的 3 個月。您 B 部分保障開始的時間取決於您登記加入 B 部分的時間。

- 若您在**生日之前 3 個月**登記加入，您的聯邦醫療保險將自您生日所在月份的第一天生效。
- 若您在**生日當月**登記加入，您的保險將自下個月的第一天生效。
- 若您在**生日之後的 1 個月**登記加入，您的保險將於兩個月後生效。
- 若您在**生日過兩個或三個月之後**登記加入，您的保險將自 3 個月後生效。

註：對於出生於當月第一天的人，醫療保險資格就從上個月第一天開始。

我的 **7** 個月首次參加期是什麼時候？



Special Enrollment Period (SEP)

If you or your spouse are **actively employed** and you have **health insurance** through that current/active employer or union, you may not need to enroll in Medicare Part B when you first become eligible; contact the employer or union as to whether they require enrollment in Part B.

Having active employer-based coverage allows you to 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. One will need the employer to complete a 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

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 7 for information on enrolling in Part A.
- ✓ **COBRA** coverage is NOT health insurance from an active employer and therefore does not allow one to qualify for a Special Enrollment Period.

When Is My Special Enrollment Period?

While you have coverage from your employer

8-months after 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 a 10% premium penalty 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.

You apply for Medicare benefits by reaching out to the Social Security Administration. You can call 1-800-772-1213, visit a local Social Security office, or you may be able to enroll online at www.socialsecurity.gov.

特定參加期 (SEP)

若您或配偶**現為受雇就業**並經由該雇主取得有效的**醫療保險**，當您初次符合資格時，可能無須登記加入聯邦醫療保險 B 部分；請聯絡雇主或工會查詢他們是否需要登記加入 B 部分。

擁有來自雇主的有效醫療保險，您就有資格在您仍在工作時，或是在您雇主醫療保險停止後 8 個月內以 SEP 登記加入 B 部分。申請人需要雇主填妥表格 CMS-L564，其中會記載雇主相關保險。表格可於下列網址取得：https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-L564E.pdf

給具有以雇主為基礎之保障人員的提示：

- ✓ 如果您登記加入了聯邦醫療保險 A 部分，您就無法再撥款至健康儲蓄帳戶 (HSA)。請參閱第 7 頁以取得登記加入 A 部分的資訊。
- ✓ **COBRA** 保障「並不是」透過活躍雇主提供的健康保險，因此不具在「特定參加期」登記加入的資格。

我的特定參加期是什麼時候？

當您透過雇主獲得保險時

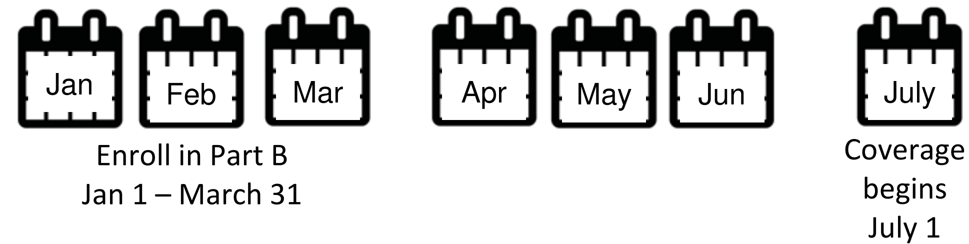
在您以雇主為基礎的保險結束之後的 8 個月

一般參加期 (GEP)

如果您未在 IEP 期間登記加入，而且同時沒有雇主醫療保險而不符合特定參加期 SEP 的資格，您就需要等候至一般參加期 (GEP)，才能登記加入 B 部分。GEP 是每年的 1 月 1 日至 3 月 31 日，但 B 部分保障必須在 7 月 1 日之後才會開始。此外，您可能會被處以延遲登記罰金。延遲登記罰金是每完整 12 個月保費 10% 的罰金，而您在這段期間沒有聯邦醫療保險 B 部分或透過現任雇主提供的保險。這代表如果您延遲登記加入 B 部分的時間達 12 個月，依據目前年度的標準 B 部分保費，您將必須支付 B 部分保費 + 10% 保費附加費用。

您要聯絡社會安全局申請聯邦醫療保險才能享有福利。您可以致電 1-800-772-1213 或造訪當地社會安全局辦事處，也可以造訪 www.socialsecurity.gov 線上登記加入。

When Is The General Enrollment Period?



Enrolling in Medicare Part A is more flexible that Part B. 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 date they become Medicare-eligible. Those who do not have 40 quarters 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-March 31, with coverage effective July 1. These individuals may incur a Late Enrollment Penalty.

Medicare Card Replacement: Medicare cards used to have a Social Security number as the identifier. By the end of 2018, all Medicare beneficiaries should have received a Medicare card with a randomly assigned identifier, known as a Medicare beneficiary identifier (MBI). The MBI is made up of 11 characters, consisting of both uppercase letters and numbers. Spouses will each have their own unique MBI, regardless of whether one spouse has Medicare based on the other spouse's work record. If you need to replace your Medicare card, call 1-800-MEDICARE or log into your MyMedicare.gov account to print one.

Choices in the Medicare Program

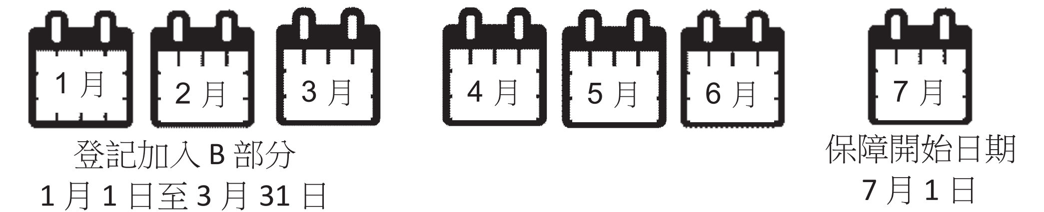
Medicare beneficiaries have a choice in how they receive their Medicare benefits (see page 3 for a decision tree). They can either receive Original Medicare, in which they use their red, white and blue Medicare card for all Part A and Part B covered services, OR they can receive their Medicare benefits through a Medicare Advantage plan, in which a private company provides them with all Medicare benefits. Medicare Advantage enrollees cannot submit bills to Medicare. This section below explains how Original Medicare functions, as well as costs in the original Medicare program. See page 26 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.

Medicare Advantage enrollees get their Part A benefits through their plan and cannot submit bills to Medicare.

一般參加期 **(GEP)** 是什麼時候？



登記加入 B 部分
1 月 1 日至 3 月 31 日

保障開始日期
7 月 1 日

登記加入聯邦醫療保險 A 部分比 B 部分更具彈性。65 歲時符合 A 部分免保費資格的個人可隨時加入聯邦醫療保險 A 部分，而且保障可往回追溯最多 6 個月。未透過社會安全局取得 40 個工作季點的個人可申請 A 部分並支付保費。這些個人只能在首次參加期登記加入，之後只能在 1 月 1 日至 3 月 31 日的一般參加期登記加入，其保障自 7 月 1 日生效。這些個人可能需繳交延遲登記罰金。

更換聯邦醫療保險卡：聯邦醫療保險卡上標有作為標識碼的社會安全號碼。在 2018 年年底之前，所有聯邦醫療保險受益人都應該會收到一張聯邦醫療保險卡，卡片上會有隨機給予的標識碼，這也稱為聯邦醫療保險受益人標識碼 (MBI)。MBI 由 11 個字元組成，同時包含大寫字元及數字。配偶雙方均會獲得各自唯一的 MBI，無論其中一方的聯邦醫療保險是否有賴於另一方的工作記錄。如果您需要更換聯邦醫療保險卡，請致電 1-800-MEDICARE 或登入 MyMedicare.gov 帳戶來列印一張卡片。

聯邦醫療保險計畫選擇

聯邦醫療保險受益人能夠選擇如何接收他們的聯邦醫療保險福利（請參閱第 3 頁以檢視決策樹）。他們可以享有聯邦醫療保險原始計畫 (Original Medicare)，使用紅、白、藍的聯邦醫療保險卡來支付所有 A 部分與 B 部分涵蓋的服務，或是可透過聯邦醫療保險優勢計畫 (Medicare Advantage) 享有福利 - 在此情況下，會由私人公司為其提供所有聯邦醫療保險福利。聯邦醫療保險優勢計畫的登記加入者無法向聯邦醫療保險提交帳單。以下區域說明聯邦醫療保險原始計畫如何運作，以及此原始計畫的費用。如需聯邦醫療保險優勢計畫的詳細資訊，請參閱第 26 頁。

聯邦醫療保險 A 部分的保險賠付

聯邦醫療保險 A 部分承保住院治療、專業護理設施、居家護理和安寧療護。

聯邦醫療保險優勢計畫的參加者是透過該計畫取得 ***A*** *部分的保險賠付獲得保障，而非將帳單遞交聯邦醫療保險。*

Inpatient Hospital Care:
Medicare pays for up to 90 days of medically necessary care in either a Medicare-certified general or 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 which 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 190 days have been used, Medicare will pay for additional inpatient psychiatric care only in a general hospital.

Medicare Part A helps pay for a semi-private room, meals, regular nursing services, rehabilitation services, drugs, medical supplies, laboratory tests and X-rays while an inpatient. 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:
Care in a skilled nursing facility (SNF) is covered by Medicare Part A following a minimum three-day stay as an impatient 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

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 towards the minimum 3-day inpatient stay that allows for Medicare Part A coverage 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 can be covered by either Part A or Part B, and is covered at 100%. Part A covers up to 100 days of home care following a minimum 3-day inpatient stay, or a covered stay in a SNF. Part B covers home care under other circumstances; 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, 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 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 48 for more information on MLTC.

住院治療：
於權益期間在聯邦醫療保險認可的綜合醫院或精神病院接受必要治療，聯邦醫療保險將賠付最多達 90 天。**權益期**從您辦理住院開始，算至您連續 60 天未在醫院或專業護理設施接受住院治療為止。一段權益期結束後，無論何時您再次接受住院治療，即開始另一段權益期。聯邦醫療保險受益人在每一段權益期的第 90 天之後，都有 60 天終身儲備期 (lifetime reserve days)。

對於在精神病院所提供的住院精神病治療，聯邦醫療保險將賠付的終身儲備期最高期限為 190 天。當終身儲備期 190 天用罄之後，聯邦醫療保險將僅賠付受益人在綜合醫院接受住院精神病治療。

住院時，聯邦醫療保險 A 部分會幫助支付雙人病房、膳食、普通護理服務、康復服務、藥品、醫療用品、醫療檢驗和 X 光。您還會得到下列承保項目：使用手術室和恢復室、心理健康服務、加護病房和心臟重症加護病房，以及所有其他的必要醫療服務和醫療用品。

專業護理設施：
以住院病人身份在醫院住院至少三天（不含出院日），專業護理設施 (SNF) 護理將由聯邦醫療保險 A 部分賠付。聯邦醫療保險所提供的賠付是權益期內長達 100 天的專業護理設備費用。

觀察情況

如果當事人被留院觀察超過 24 小時，醫院必須提供醫療補助受益人一份醫療補助出院觀察注意事項 (Medicare Outpatient Observation Notice，縮寫 MOON)。「觀察」期間醫療費用由 B 部分承保，非 A 部分，並且不計入最低 3 天的入院日，不受醫療補助 A 部分的專業護理設施保險。

家庭醫療護理：若您返家但因傷病而需要專業護理，由聯邦醫療保險的居家護理機構，在您家中提供的護理可由聯邦醫療保險支付。A 部分或 B 部分會賠付居家護理的費用，而且 100% 承保。在住院治療或在專業護理設施中的承保住院最少 3 天之後，A 部分承保最多達 100 天的居家護理。B 部分會承保其他情況下的居家護理；申請居家護理的條件不需要之前住院。這些服務可能在部分時間提供或間歇提供，而非全日性的。專業護理可得到保險賠付，包括專業護理，物理、職能和言語治療。若您是接受專業居家護理，可能也有資格接受其他服務，例如居家保健助理和醫療社工等居家護理服務。

同時具有聯邦醫療保險和醫療補助且接受醫療補助的家居護理服務的人士必須登記加入管理式長期護理 (MLTC) 計畫。請參閱第 48 頁以取得 MLTC 的詳細資訊。

Hospice Care: Medicare beneficiaries who are terminally ill can elect to receive hospice care rather than regular Medicare benefits. Hospice care emphasizes providing comfort and relief from pain. Hospice care 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 (2020)

Premium: premium-free for most people because they or their spouse have at least 40 quarters of coverage with Social Security.

- Those without 40 quarters of coverage with Social Security can pay a monthly premium for Part A coverage.
  - If you have less than 30 quarters of Social Security coverage, your Part A premium will be $458 a month**.** If you have 30 to 39 quarters of Social Security coverage, your Part A premium will be $252 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 41.

Inpatient Costs:
Deductible: $1,408 per benefit period (covers days 1-60)
Additional cost sharing:

- $352 per day for days 61-90
- $704 per Lifetime Reserve Day (60 days)

Skilled Nursing Facility Costs:
Days 1-20: Medicare pays 100%
Days 21-100: $176 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. **Note: A stay in a skilled nursing facility is not long term care.**

Medicare Part B Benefits

Part B of Medicare pays for a wide range of medical services and supplies, but most important is that it helps pay for doctor bills. The medically necessary services of 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 covered services:

- Physician services
- Outpatient hospital services
- Mental health care
- Blood, after the first 3 pints
- Ambulance transportation
- Physical, speech & occupational therapy
- Preventive & screening tests
- Flu, pneumonia & hepatitis B vaccines
- Injectibles
- X-rays
- Lab tests (covered at 100%)
- Durable medical equipment
- Medical supplies (including test strips and lancets used with blood glucose monitors)
- Home care (see page 8)

安寧療護：聯邦醫療保險受益人若患有絕症，可以選擇接受安寧療護，而非一般的聯邦醫療保險賠付。安寧療護強調提供舒適環境並減輕病痛。安寧療護一般是在家中提供，而且可包含物理護理、諮詢、處方藥、設備和臨終疾病及相關情況的用品。

A 部分費用 (2020)

保費：只要本人或配偶累積至少 40 個社會安全工作季點，多數人都有資格獲得儲蓄計畫。

- 如果未取得 40 個社會安全工作季點，可支付月保費以取得 A 部分保險。
  - 若您少於 30 個社會安全工作季點，A 部分保費將是每月 $458。若您累積了 30 至 39 個社會安全工作季點工作季點，A 部分保費將是每月 $252。
  - QMB 聯邦醫療保險免保費計畫也能為無資格獲得免保費 A 部分者支付 A 部分的保費，請參閱第 41 頁。

住院費用：
自負額：每一段權益期為 $1,408（保障 1-60 天）
其他費用分攤：

- 第 61-90 天，每天 $352
- 終身儲備期：每天 $704（60 天）

專業護理設施費用：
第 1-20 天：聯邦醫療保險會100%全額賠付
第 21-100 天：每天 $176
若您在權益期內所需要的醫療護理超過 100 天，從第 101 天開始的全部費用將由您自行負擔。**註：住在專業護理設施並非長期照護。**

聯邦醫療保險 (MEDICARE) B 部分的保險賠付

聯邦醫療保險 B 部分支付範圍廣泛的醫療服務和用品，但最重要的是它能幫助支付醫生費用。醫療上必要的醫生服務都有承保，不論護理是於住家、醫生的辦公室、診所、療養院或醫院之中提供。B 部分保障的服務：

- 醫生服務
- 醫院門診服務
- 心理健康護理
- 最初 3 品脫之後的血液
- 救護車運送
- 物理、言語及職能治療
- 預防性與篩檢檢驗
- 流感、肺炎及 B 型肝炎疫苗
- 注射
- X 光
- 實驗室化驗 (100% 承保)
- 耐久性醫療器材
- 醫療用品（包含隨附於血糖監測器的試紙條和採血針）
- 居家護理（請參見第 8 頁）

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

Medicare Advantage enrollees get their Part B benefits through their plan and cannot submit bills to Medicare.

What Do You Pay Under Part B?

Medicare Part B beneficiaries are responsible for paying a monthly premium, an annual deductible, and a 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 (2020)

Standard monthly **premium** is $144.60. About 4% of Medicare beneficiaries pay less than this amount.

- Higher income individuals (over $87,000 for individuals; $174,000 for married couples) will be responsible for higher premiums, known as the Income Related Monthly Adjustment Amount (IRMAA). Social Security determines whether each person is subject to IRMAA by looking at tax returns from 2-years prior; IRMAA is re-evaluated each year. For example, in 2020, SSA looks at your 2018 tax filings. You can request that SSA reconsider your IRMAA amount due to a life-changing event by submitting form SSA-44 (www.ssa.gov/forms/ssa-44-ext.pdf). See page 64 for more information for the current IRMAA amounts.

Annual Deductible: $198

Co-insurance: 20% (Medicare pays 80% of Medicare-approved charges)

Can You Get Help with Cost-Sharing Under Original Medicare?

There are several ways to help cover the cost-sharing under Original Medicare, including:

- **Medicare Supplement Insurance (Medigap)** helps Medicare beneficiaries pay their share of the costs not covered by Medicare. These policies fill in the "gaps" of Medicare's reimbursement, but only for the approved services under Medicare coverage. See page 19 for information on Medigap policies.
- **Retiree/Union Benefits** may work with Original Medicare. Speak to your benefits administrator to understand the policy.
- **Medicaid** works to cover Medicare cost-sharing, as long as you meet Medicaid eligibility requirements. See page 45 for more information.

How Much Can Providers Charge for Services?

There are different relationships that doctors and medical providers can choose to have with the Medicare program. The provider's category affects how much you will pay for their services. Providers can be "Participating" providers, "Non-Participating" providers, or they can "Opt Out" of the Medicare program.

聯邦醫療保險不會賠付例行性視力（眼鏡）、助聽器、牙科、例行性年度健康檢查和其他不承保的服務。

聯邦醫療保險優勢計畫的參加者是透過該計畫取得 B 部分的保險賠付獲得保障，而非將帳單遞交聯邦醫療保險。

您在 B 部分需要支付的費用為何？

聯邦醫療保險 B 部分受益人須支付月保費、年自付額以及大部分服務的共保額。領取社會安全福利金的受益人的每月保費從他們的支票中扣除。未領取社會安全福利金的人通常需按月繳納保費。

B 部分費用 (2020)

標準月度**保費**為 $144.60。大約 4% 的醫療保險受益人將會支付低於這個金額。

- 收入較高的個人（個人高於 $87,000；已婚配偶高於 $174,000）將會負責更高的保費，這稱爲收入相關月度調整額 (IRMAA)。社會安全通過審核前兩年的報稅來判定每個人是否符合 IRMAA；IRMAA 每年重新評估一次。例如，在 2020 年，SSA 審核您 2018 年的納稅申報。您可以因爲生活改變事件透過提交 SSA-44 表 (www.ssa.gov/forms/ssa-44-ext.pdf) 要求 SSA 重新考慮您的 IRMAA 金額。請參閱第 64 頁以取得目前 IRMAA 金額的詳細資訊。

年自負額：$198

共保額： 20%（聯邦醫療保險會賠付 80% 的聯邦醫療保險核准費用）

您是否能獲得聯邦醫療保險原始計畫的費用分攤補助？

有數種方法有助於獲得聯邦醫療保險原始計畫的費用分攤補助，包含：

- **聯邦醫療保險補充保險 (Medigap)** 協助聯邦醫療保險受益人支付聯邦醫療保險不賠付的分攤費用部分。這些補充性保險能彌補聯邦醫療保險償款的「差額」，但僅限於依聯邦醫療保險承保項目所核准的服務。關於醫療補充保險的規定請參見第 19 頁。
- **退休福利或工會福利**可與聯邦醫療保險原始計畫搭配使用。諮詢福利管理員，以瞭解保單內容。
- 只要您符合**醫療補助 (Medicaid)** 資格要求，醫療補助可承保聯邦醫療保險費用分攤。詳情請參見第 45 頁。

醫療業者可就服務項目收取多少費用？

醫生與醫療業者可選擇與聯邦醫療保險計畫之間存在不同的關聯。醫療業者的類別會影響您對其服務所需要支付的款項。醫療業者可以「參與」、「不參與」或「退出」聯邦醫療保險計畫。

- If a provider is a "**Participating**" provider, they will always accept the Medicare allowed amount as payment in full (Medicare pays 80% and the beneficiary pays 20%, after you meet the Part B deductible). If you want to find out whether a provider is participating, you can ask, "Is the doctor a participating provider in the Medicare program?" It is best to ask this question when making an appointment, and also to confirm this information at the time of the appointment.

- "**Non-Participating**" providers still have a relationship with the Medicare program; how this category differs from "Participating" providers is in how much they can charge to see a Medicare beneficiary. Non-participating providers can 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 NY, have lower limiting charges. For most physician services performed in NY, if the physician does not accept assignment, they can charge no more than 5% above what Medicare allows, with the exception of home and office visits, where they can bill up to the 15% Federal limiting charge.
        - NOTE: It is common for providers who do not accept assignment to request payment in full 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 written contract with any Medicare beneficiary who seeks their treatment. The provider will set a fee for each specific service and the patient agrees to pay the costs, understanding that Medicare will not pay that doctor or reimburse the beneficiary. A Medicare supplement policy (Medigap) will not pay any of these costs either. The Medicare beneficiary is still covered by Medicare for services by other providers.

Advance Beneficiary Notice of Non-Coverage

There is no prior authorization in Original Medicare. As long as Medicare considers a service medically necessary, it will pay for the service, subject to cost-sharing.

If a provider is not sure that Medicare will consider a service "medically necessary," and therefore not approve a claim, the provider must present the beneficiary with an "Advance Beneficiary Notice of Non-coverage (ABN)" form, indicating the service for which Medicare may not pay. The form must specify the service in question; the date of the service; a specific reason why the service may not be paid for by Medicare; and a place for the beneficiary to sign as proof that they understand and accept responsibility to pay for the service. The beneficiary is not responsible to pay unless he or she signed a valid ABN. The ABN does not apply to services never covered by Medicare (i.e. hearing aids), which are always the beneficiary's responsibility. The beneficiary retains appeal rights, even with a signed ABN. See page 13 for a sample ABN.

- 若醫療業者「**參與**」，他們將始終接受聯邦醫療保險所容許的金額作為收取的全額（在您滿足 B 部分自付額條件之後，聯邦醫療保險支付 80%，受益人支付 20%）。若您想知道醫療業者是否「參與」，您可以詢問：「醫生是否參與聯邦醫療保險計畫？」最好在作出預約時詢問，也可以在就診時確認此資訊。

- 「**不參與**」的醫療業者仍可以與聯邦醫療保險計畫存在關聯；這類醫療業者與「參與」醫療業者的不同之處在於他們向聯邦醫療保險受益人的收費情形。不參與的醫療業者可針對每項理賠「**接受費用安排**」或「**不接受費用安排**」。若您知悉醫療業者不參與計畫，則可以問：「醫生是否對我的理賠接受費用安排？」
    - 若醫療業者**接受費用安排**，其將接受聯邦醫療保險就特定服務所核准的費用金額，而且在您滿足 B 部分自付額條件之後，對您的收費不得超過 20% 的共保額（就大多數服務而言）。
    - 若醫療業者**不接受費用安排**，則費用將受到「限制收費」的約束，並且是聯邦醫療保險所核准的金額之外的額外收費。聯邦限制費用為 15%。有些州（包含紐約州）的限制費用更低。對於在紐約州執行的大多數醫生服務，若醫生不接受安排，他們收取的費用不得超過聯邦醫療保險允許的 5%，但居家訪視及診所看診則不在此限，他們對於此類項目可收取高達 15% 的聯邦限制費用。
        - 註：對於不接受費用安排的醫療業者而言，常見的是要求在服務之時全額付款。醫療業者將會向醫療保險提交索賠，而醫療保險將會為受益人報銷 80%。
- 「**退出**」聯邦醫療保險計畫的醫療業者必須與任何尋求其治療的聯邦醫療保險病患訂立私人書面契約。醫療業者將為每項服務設定收費，而病人同意支付費用，並且明白聯邦醫療保險不會付款予醫生或償款予受益人。聯邦醫療保險的補充性保險 (Medigap) 也不會支付任何這類費用。聯邦醫療保險受益人接受其他醫療業者所提供的服務時，仍然受到聯邦醫療保險的保障。

受益人未受保項目事前通知

原始聯邦醫療保險不需要事先授權。只要聯邦醫療保險認為服務有醫療必要，便會賠付該服務的費用，但須受費用分攤約束。

若醫療業者不確定聯邦醫療保險會否考慮某種服務「醫療必要性」，因而不核准索賠，該醫療業者必須為受益人提供「受益人未受保項目事前通知 (ABN)」表，說明聯邦醫療保險可能不會支付的服務。該通知必須指定有疑問的服務項目；服務日期；該服務不能獲得聯邦醫療保險賠付的特定原因；並要求受益人簽名以證明他們明白並同意自行付費接受服務。除非受益人已簽署有效的 ABN，否則其不負責付款。ABN 不適用於聯邦醫療保險從不承保的、一直由受益人負責的服務項目（如助聽器）。受益人保留申訴權，即使已有簽署 ABN 的亦然。請參閱第 13 頁以取得範例 ABN。

Medicare Summary Notice
A Medicare Summary Notice (MSN) 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, a MSN will be mailed as the claims are processed, along with a check to the beneficiary for the 80%, if the beneficiary has already paid for the service.

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

Beneficiaries wishing to see their claims sooner can call 1-800-MEDICARE, or they can access their MSNs only by logging into www.mymedicare.gov. One can request to receive the MSN in Spanish by calling 1-800-MEDICARE.

To view a sample MSN for Medicare Parts A and B, as well as an explanation for reading the MSN, visit www.medicare.gov/pubs/pdf/SummaryNoticeA.pdf and www.medicare.gov/pubs/pdf/SummaryNoticeB.pdf.

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, such as that you are being discharged from the hospital too soon, call Livanta at 1-877-588–1123 (TTY: 1-855- 887-6668). If you request an immediate review by Livanta, you will not be financially responsible for additional hospital charges until noon of the day following your receipt of Livanta's review decision.

聯邦醫療保險摘要通知
聯邦醫療保險受益人將於每一季收到郵寄的聯邦醫療保險摘要通知 (MSN)，其 A 部分和/或 B 部分理賠申請已由接受聯邦醫療保險安排的醫療業者提交。至於未接受聯邦醫療保險安排之醫療業者的索賠，聯邦醫療保險摘要通知將於理賠申請處理後寄出。若受益人已為該服務預付費用，受益人將一併收到 80% 之費用的支票償款。

聯邦醫療保險摘要通知還附有說明聯邦醫療保險理賠申請遭駁回時該如何申訴的資訊。

若受益人希望申訴案件能夠盡快獲得處理，則可以致電 1-800-MEDICARE，或是可以只透過登入 www.mymedicare.gov 來存取其 MSN。申請人可致電 1-800-MEDICARE 以索取西班牙文版本的 MSN。

欲查看聯邦醫療保險 A 部分和 B 部分的聯邦醫療保險摘要通知範例，以及聯邦醫療保險摘要通知的閱讀說明，請造訪 www.medicare.gov/pubs/pdf/SummaryNoticeA.pdf 和 www.medicare.gov/pubs/pdf/SummaryNoticeB.pdf。

聯邦醫療保險申訴
如果您不同意聯邦醫療保險保障或付款決策，您可以向聯邦醫療保險提出申訴。聯邦醫療保險摘要通知 (MSN) 提供申訴程序的資訊。您可能需要向醫療護理提供者索取其他資訊，以支持您的個案。請留意提出申訴的時間限制。

若有護理品質投訴或若覺得聯邦醫療保險 A 或 B 部分服務太早結束，以致於讓患者太早出院，請致電 Livanta：1-877-588-1123 (TTY：1-855- 887-6668)。若是請求 Livanta 立即進行審查，在收到 Livanta 審查決定的次日中午之前，都無須負擔任何額外的住院費用。

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

Advance Beneficiary Notice of Noncoverage (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:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

A. 通知者：
B. 病人姓名： **C.** 身份證號碼：

受益人未受保項目事前通知 (ABN)

註：如果聯邦醫療保險不賠付下列的 **D.** ，您可能必須支付費用。

聯邦醫療保險不會賠付所有的項目，即便是您自己或醫護業者有充分理由認為需要某些醫護服務。聯邦醫療保險可能不會賠付下列的 **D.** 。

D.	E. 聯邦醫療保險不賠付的理由：	F. 估計費用

您需要馬上採取的措施：

閱讀本通知，才能對自己的醫療護理做出知情決策。

閱讀完畢後，向我們提出您可能會有的任何問題。

從下方的選項中選擇是否要接受上述的 **D.** 。

註：如果選擇選項 1 或 2，我們可能協助您利用您可能擁有的任何其他保險，但是聯邦醫療保險不能要求我們這麼做。

G. 選項： 只能勾選一項。我們不能為您勾選。

☐ **選項 1**。我要接受上述的 **D.** ____________ 。您可以要求馬上付款，但是我也希望聯邦醫療保險能收到帳單，以便對賠付做出正式決定，並以聯邦醫療保險摘要通知 (MSN) 寄送給我。我理解，如果聯邦醫療保險不賠付，我要負責支付費用，但是**我可以向聯邦醫療保險上訴**，只要遵照聯邦醫療保險摘要通知上的指示即可。如果聯邦醫療保險賠付，我所支付的費用將在扣除共付額或自付額之後被退款。

☐ **選項 2**。我要接受上述的 **D.** ____________ ，但不要向聯邦醫療保險收費。由於我有責任支付費用，可以要求我馬上付款。**如果未向聯邦醫療保險收費，我不能提出上訴。**

☐ **選項 3**。我不想接受上述的 **D.** ____________ 。我理解，這項選擇表示我**不必**負責支付費用，而且**我不能上訴以試探聯邦醫療保險是否會賠付。**

H. 其他資訊：

本通知僅提供我們的看法，並非聯邦醫療保險的正式決定。如果您對本通知或聯邦醫療保險的計費有其他疑問，請致電 **1-800-MEDICARE** (1-800-633-4227／**聽障專線：** 1-877-486-2048)。

在下方簽名即表示您已收到並理解本通知。您也收到一份副本。

I. 簽名：	J. 日期：

根據 1995 年減少文書作業法 (Paperwork Reduction Act of 1995)，除非顯示有效的 OMB 管理號碼，否則不必理會資訊收集表。此份資訊收集表的有效 OMB 管理號碼為 0938-0566。填寫此份資訊收集表所需的時間估計為每份平均 7 分鐘，包括查閱說明、搜尋現有的資料資源、蒐集所需資料，以及填寫並檢查資訊收集表。如果您對估計時間的正確性有意見，或欲對改進本表格提供建議，請寫信至：CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850。

CMS-R-131 表格 (Exp. 03/2020) 表格核准 OMB 號碼 0938-0566

MEDICARE PREVENTIVE SERVICES

Medicare covers nearly all preventive services at 100%, 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	Procedures to identify bone loss, or determine bone density are covered every 24 months. Women at risk for osteoporosis or who are receiving osteoporosis drug therapy and persons with spine abnormalities qualify for these procedures.
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 face-to-face 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: covered once every 12 months. Flexible Sigmoidoscopy: covered once every 48 months. Colonoscopy: covered once every 24 months if you are at higher risk for colon cancer. If you are 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. Cologuard™ test: 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 by your primary care doctor once every 12 months.

聯邦醫療保險預防性保健服務

幾乎全部的預防性保健服務都可以獲得聯邦醫療保險 100% 承保，不受 B 部分自付額和/或 20% 共保額的限制。聯邦醫療保險承保下列的預防性保健服務：

腹主動脈瘤篩檢	醫療補助提供一次腹主動脈瘤篩檢。如果您家族有腹主動脈瘤病史，或是累計已吸入 100 根香菸的 65 至 75 歲男性。
酗酒檢測與諮商輔導	聯邦醫療保險承保每年進行一次酗酒檢測。對於篩檢呈陽性反應者，聯邦醫療保險每年亦將對最多四次簡短的面對面行為介入輔導提供賠付。
骨質密度檢查	用以判斷骨質流失或骨質密度的檢查程序，每 24 個月可進行一次。有骨質疏鬆症危險或正在接受骨質疏鬆症藥物治療的婦女，以及患有脊椎異常的人士，將有資格接受這類檢查程序。
乳癌篩檢（乳房透視檢查）	35 歲至 39 歲可進行一次基本乳房透視檢查。擁有聯邦醫療保險的 40 歲以上婦女，每 12 個月可做一次乳房透視檢查。有乳癌症狀出現時，不論何時所做的診斷性乳房透視都在承保範圍內。診斷性乳房透視受到 B 部分自付額和 20% 共保額限制。
心血管疾病（行為治療）	聯邦醫療保險承保每年進行一次面對面的降低心血管疾病風險門診。該門診會鼓勵使用阿斯匹靈、進行高血壓篩檢，並且提供行為諮商以提倡膳食健康。
心血管疾病篩檢	聯邦醫療保險賠付的心血管篩檢包括每 5 年檢查一次膽固醇和其他血脂肪 (lipid) 含量。
子宮頸癌及陰道癌篩檢（子宮頸抹片和骨盆腔檢查）	每 24 個月可進行一次子宮頸抹片檢查、骨盆腔檢查和臨床乳房檢查，屬於子宮頸癌或陰道癌高危險群的婦女可每 12 個月做一次檢查。擁有聯邦醫療保險的所有婦女都受到保障。 對於年齡介於 30 至 65 歲且無 HPV 症狀的女性，B 部分也承保人類乳突病毒 (HPV) 檢驗（作為子宮頸抹片檢查的一部分），每 5 年一次。
大腸癌篩檢	糞便潛血檢查：每 12 個月可檢查一次 軟式乙狀結腸鏡檢查：每 48 個月可檢查一次 結腸鏡檢查：若屬於患上結腸癌的高危險群可每 24 個月檢查一次。若非屬於高危險群則是每 10 年檢查一次，但不得在做過軟式乙狀結腸鏡檢查後的 48 個月之內進行。 鋇劑灌腸攝影：可用以取代軟式乙狀結腸鏡檢查或結腸鏡檢查；須支付聯邦醫療保險核准金額之 20%。 Cologuard™ 測試：為下列條件者承保**每 3 年一次**的測試：50 歲至 85 歲參與聯邦醫療保險者；並無顯示結直腸疾病的徵兆或症狀；以及處於患結腸直腸癌的平均風險。
憂鬱症篩檢	聯邦醫療保險承保由主理醫生所進行的憂鬱症篩檢，每 12 個月可檢查一次。

Diabetes screening	Medicare covers up to 2 diabetes screenings per year for people at risk for diabetes.
Diabetes prevention	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 to teach them to manage their condition and prevent complications.
Glaucoma tests	People at high risk for glaucoma, including people 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 1945-1965, and a yearly repeat screening for certain 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 who are age 55-77 and are either a current smoker or have quit smoking 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 will be 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: 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: 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 is for up to two individual 20 to 30 minute, face to face counseling sessions annually for those at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting.
Smoking and tobacco use cessation counseling	Counseling to stop smoking. Medicare will cover up to 8 face-to-face visits during a 12-month period for beneficiaries who use tobacco.
Vaccinations/shots	• Flu: Covered once per flu season. • Pneumonia: Usually only needed once in a lifetime. A different, second shot, is covered 12 months after you get the first shot. • Hepatitis B: Covered if at high or intermediate risk.

糖尿病篩檢	對於有糖尿病風險的人，聯邦醫療保險承保每年最多 2 次糖尿病篩檢。
糖尿病的預防	聯邦醫療保險承保一次性健康行為變更計畫，以協助預防符合臨床要求的人，以及從未確診第 1 型或第 2 型糖尿病或末期腎臟疾病 (ESRD) 的人發展成第 2 型糖尿病。
糖尿病自我管理訓練	聯邦醫療保險承保對糖尿病患者的訓練，以教導他們管理自己的症狀和預防發生併發症。
青光眼檢查	青光眼高危險人士，包括患有糖尿病或有青光眼家族病史者，每 12 個月可檢查一次。在扣除 B 部分自付額後，您應支付聯邦醫療保險核准金額之 20%。
乙肝篩檢	聯邦醫療保險補助提供年度乙肝肝篩檢，針對未施打乙肝肝疫苗的風險族群；聯邦醫療保險另提供孕婦乙肝篩檢。
丙肝篩檢	聯邦醫療保險為 1945-1965 年出生的人承保一次丙肝篩檢，並為特定的高風險人士承保每年一次的複檢。
愛滋病毒篩檢	任何要求檢測的受益人每 12 個月可進行一次。
肺癌篩檢	聯邦醫療保險為 55-77 歲的人以及現在還抽煙或在過去 15 年內戒煙的人每 12 個月承保一次肺癌篩檢。
醫療營養治療	對於患有糖尿病或腎臟疾病的受益人，聯邦醫療保險的賠付包括第一年 3 小時的一對一諮詢輔導服務，其後則是每年 2 小時。
肥胖症篩檢與諮商輔導	身體質量指數若達 30 或以上，膳食評估、密集式行為輔導以及行為治療可獲聯邦醫療保險賠付。
體檢	加入聯邦醫療保險 B 部分之後的 12 個月內可進行首次預防性體檢。另外，所有加入聯邦醫療保險 B 部分的人士，每年都可以做一次健康檢查，但在首次體檢後的 12 個月之內不得進行。
前列腺癌篩檢	手指直腸檢查：50 歲以上男性可以每 12 個月檢查一次。在扣除 B 部分自付額後，您應支付聯邦醫療保險核准金額之 20%。 前列腺特異抗原 (PSA) 血液檢測：50 歲以上男性可以每 12 個月檢查一次。
性傳播疾病感染 (STI) 篩檢與諮詢	聯邦醫療保險承保對衣原體感染、淋病、梅毒和乙肝的篩檢，以及預防性傳播疾病感染的高度密集式行為輔導 (HIBC)。聯邦醫療保險承保對衣原體感染、淋病、梅毒和 B 型肝炎的篩檢，以及預防性傳播疾病感染的高度密集式行為輔導 (HIBC)。對於可能罹患 STI 的高危險群，每年可以進行最多兩次個別的 20 至 30 分鐘面對面輔導，前提是此項服務必須由主理醫生轉介，並且是由符合聯邦醫療保險資格的主理醫生在第一線醫療環境中進行。
輔導戒煙及菸草使用	輔導協助戒煙。對於吸煙的受益人，聯邦醫療保險將賠付 12 個月之內的 8 次面對面輔導。
疫苗/預防針	• 流感：每個流感季節可注射一次。 • 肺炎：通常一生中只需要注射一次。第二針在注射第一針後 12 個月承保。 • 乙肝：若是處於中高危險狀態可獲賠付。

MEDICARE AS SECONDARY PAYER
WHO PAYS FIRST?

When a person has Medicare and other health insurance coverage, it is necessary to understand which insurance is primary, and which is secondary. The primary insurance is the one that will consider the claim first and the secondary insurance will consider any balance 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 that they 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 the beneficiary's MyMedicare.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 where someone has Medicare and insurance from a current employer:

YOU ARE...	YOUR EMPLOYER	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 plan	Less than 100 employees	First. Employer plan second.
Disabled under 65 covered by other family member plan	100 or more employees	Second. Employer plan first.
Any age with End Stage Renal Disease (ESRD) covered by employer plan of self or other family member	Any number of employees	Second for the first 30 months of Medicare enrollment. After 30 months, Medicare is primary.

聯邦醫療保險為副保險
誰先承保付費？

當個人同時擁有聯邦醫療保險和其他健康保險時，必須瞭解何者是主保險、何者是副保險。主保險是首先考量理賠的保險，副保險則是在主保險的理賠獲得賠付或遭拒之後再對任何餘額進行考量。

新參與聯邦醫療保險的人士將收到一封寄來的信函，要求填寫首次註冊問卷 (IEQ)。該問卷調查您是否透過您的雇主或家人的雇主參與團體健康保險計畫。可使用受益人的 MyMedicare.gov 賬戶在線填寫 IEQ，或致電 1-855-798-2627 透過電話完成問卷。

如有關於誰先支付的問題，或保險範圍發生變化，請致電聯邦醫療保險賠付協調員及恢復中心 (BCRC)：1-855-798-2627。

本表顯示在擁有聯邦醫療保險和目前雇主提供保險的情況下，何者先賠付：

您是...	您的雇主有...	聯邦醫療保險賠付將是...
65 歲以上，有雇主保險計畫	員工人數不及 20 人	第一順位。雇主保險計畫為第二順位。
65 歲以上，有雇主保險計畫	員工人數在 20 人或以上	第二順位。雇主保險計畫為第一順位。
65 歲以上，配偶有雇主保險計畫	員工人數不及 20 人	第一順位。雇主保險計畫為第二順位。
65 歲以上，配偶有雇主保險計畫	員工人數在 20 人或以上	第二順位。雇主保險計畫為第一順位。
65 歲以下的殘障人士，有雇主保險計畫	員工人數不及 100 人	第一順位。雇主保險計畫為第二順位。
65 歲以下的殘障人士，有雇主保險計畫	員工人數在 100 人或以上	第二順位。雇主保險計畫為第一順位。
65 歲以下的殘障人士，有其他家庭成員的保險計畫	員工人數不及 100 人	第一順位。雇主保險計畫為第二順位。
65 歲以下的殘障人士，有其他家庭成員的保險計畫	員工人數在 100 人或以上	第二順位。雇主保險計畫為第一順位。
患有末期腎臟疾病 (ESRD) 者，年齡不限，自己有雇主保險計畫，或是有其他家庭成員的保險計畫	員工人數不限	登記加入聯邦醫療保險後的首 30 個月為第二順位。30 個月之後，則以聯邦醫療保險為主保險。

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 there are 20 or more employees in the company where a Medicare beneficiary or spouse work, the EGHP is primary and Medicare is secondary. If there are fewer than 20 employees, then Medicare is primary and the EGHP is secondary. Medicare Part B is always an option to those who are working who have employer coverage. Some employers require that those who are eligible for Medicare enroll in Medicare Parts A and/or B; it is advised to contact the employer about this issue.

  At the time of retirement, the employee needs to consider enrolling in Medicare Part B, since Medicare Part B will be the primary insurance upon retirement. See page 6 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 family member's active employment, for an employer of 100 or more employees, the EGHP is primary and Medicare is secondary. If there are fewer than 100 employees, then Medicare is primary and the EGHP is secondary.

- **End Stage Renal Disease (ESRD):** Some individuals are eligible for Medicare Part B coverage because they have End Stage Renal Disease and are either receiving maintenance dialysis treatments or have had a kidney transplant. If there is 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. In cases where the Workers Compensation plan does not pay promptly, Medicare may make a conditional payment; Medicare would then be reimbursed when the payment comes through. The Benefits Coordination & Recovery Center (BCRC) assists with this function.

- **Liability Insurance and Medicare**: In situations of an accident or injury, the expenses of medical care 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 for these cases to avoid delays in reimbursement to providers and liability to beneficiaries. Medicare will pay the claim and later seek to recover the conditional payments from the settlement amount.

Retiree health coverage: Generally speaking, in cases where one has 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.

雇主團體健康保險（EGHP）和聯邦醫療保險：當人們擁有雇主保障和聯邦醫療保險，則聯邦醫療保險屬於主保險或副保險視雇主的規模而定。

- **65 歲以後繼續工作**──若聯邦醫療保險受益人或配偶所工作的公司擁有 20 名以上員工，則 EGHP 為主保險，而聯邦醫療保險為副保險。若公司員工人數不及 20 人，則以聯邦醫療保險為主保險，而 EGHP 為副保險。有工作並有雇主保險的人士始終可以選擇登記加入聯邦醫療保險 B 部分。有些雇主要求符合聯邦醫療保險資格者須加入聯邦醫療保險 A 部分和/或 B 部分；建議洽詢雇主以瞭解此點。

  在退休時，該員工需要考慮加入聯邦醫療保險 B 部分，因為一旦退休，聯邦醫療保險 B 部分將成為其主保險。請參閱第 6 頁以取得聯邦醫療保險特定參加期的資訊。

- **殘障及聯邦醫療保險：**如果您因為自己、配偶或家庭成員受雇而擁有醫療保險保障，若公司員工人數在 100 人或以上，則 EGHP 為主保險，而聯邦醫療保險為副保險。若公司員工人數不及 100 人，則以聯邦醫療保險為主保險，而 EGHP 為副保險。

- **末期腎臟疾病（ESRD）：**有些人符合聯邦醫療保險 B 部分保障的資格是因為患有末期腎臟疾病，並且接受長期洗腎或曾進行腎臟移植。如果是 EGHP（無論是否基於當下的受雇情況），則在醫療補助合格條件的前 30 個月期間，該保障為主保險。30 個月之後，則以聯邦醫療保險為主保險。

- **勞工賠償和聯邦醫療保險：**在與工作有關的受傷事件中，勞工賠償通常是主保險，並且只賠付與受傷有關的醫療護理支出。如果勞工賠償保險未能及時賠付，聯邦醫療保險可以進行有條件賠付；等勞工保險賠付以後再收回。聯邦醫療保險賠付協調員 & 恢復中心 (BCRC) 具有該項職能。

- **責任保險和聯邦醫療保險**：在意外事故或受傷的情況下，醫療支出可能會由其他型態的保險支付，例如：無過失保險或汽車保險、住宅綜合險或執業過失險。由於許多理賠申請都需要很長時間才能解決，聯邦醫療保險可以進行有條件賠付，以避免對醫療業者的償款延宕並成為受益人的欠款負擔。聯邦醫療保險將先進行理賠，日後再尋求從結算金額中收回有條件的賠付。

退休人士健康保險：一般而言，若是同時擁有聯邦醫療保險和退休人士健康保險，聯邦醫療保險為主保險，退休人士保險為副保險。對於某些人而言，退休者福利比較類似聯邦醫療保險的補充保險，但對其他人而言，則比較類似醫療保險優勢計畫的作用。您必須諮詢福利管理員，以瞭解自己的退休福利如何與聯邦醫療保險協調。

Federal Employee Health Benefits (FEHB): Unlike most retiree plans that require enrollment in Medicare, the Federal Employees Health Benefits (FEHB) program can continue to pay as primary if the individual does not enroll in Medicare. FEHB members should enroll in Part A to cover some of the costs that the FEHB plan may not cover, but can make a decision about whether to enroll in Part B. FEHB members have three choices:

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. 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 will be subject to a late enrollment penalty in the form of a higher monthly Part B premium.
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 reducing out-of-pocket costs and 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 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.

聯邦員工健康福利 (FEHB)：不同於需要登記加入醫療保險的大多數退休者計畫，若個人沒有登記加入聯邦醫療保險，聯邦員工健康福利 (FEHB) 計畫將會繼續支付爲主保險。FEHB會員應該登記加入 A 部分，以涵蓋 FEHB 計畫可能會未涵蓋的某些費用。FEHB 會員有三個選擇：

1. FEHB 且無 B 部分。會員可以繼續進行其 FEHB 保險，不須登記加入聯邦醫療保險，這將會為他們節約每月 B 部分保費的費用。若這些會員後來決定他們想要 B 部分，則需要等待，直至下一個一般參加期時，才能登記加入 B 部分，而且需以每月較高 B 部分保費的形式繳交延遲登記罰金。
2. FEHB 和 B 部分。會員可以繼續進行其 FEHB 保險並登記加入 B 部分。有些 FEHB 計畫可能會激勵登記加入聯邦醫療保險，例如降低付現成本，並放棄 FEHB 計畫共付額、自付額以及共保額。選擇同時參與聯邦醫療保險和 FEHB 的會員將會需要同時支付 FEHB 和 B 部分保費。
3. B 部分且無 FEHB。與大多數退休人員不同，聯邦退休人員能夠**暫停**（而非取消）其退休人員保險，以登記加入聯邦醫療保險優勢計畫，其中可能具有較低的月度保費或根本沒有增加保費。選擇這個選項的個人仍將需要登記加入 B 部分，以便登記加入聯邦醫療保險優勢計畫，但是他們將會避免更高費用的 FEHB 保費。另外，他們可能會在下一個 FEHB 開放參加期內選擇重新恢復 FEHB 保險。

請造訪美國人事管理局 (OPM) 網站以取得醫療保險及 FEHB 的詳細資訊：http://www.opm.gov/insure/health/medicare/index.asp，http://www.opm.gov/healthcare-insurance/fastfacts/fehbmedicare.pdf 以及 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 cover the costs sharing in 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 offers reimbursement for out-of-pocket health service costs not covered by Medicare, which are the beneficiary's share of costs. For example, a Medigap policy might cover the Part A deductible, the Part B outpatient co-insurance of 20% of allowed charges, and other costs. **Note that some plans only cover 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 policies are available?

There are ten standard Medigap policies available, designated "A" through "N." Each of the policies covers the basic benefit package, plus a combination of additional benefits. Older Medigap policies from before the 1992 standardization are still in effect, but cannot be offered to new enrollees. Individuals with an older policy can switch to a new, standard policy, but would not be allowed to go back to the old policy. Effective June 1, 2010, 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.

New!

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

When can I enroll in a Medigap policy?

In New York State, you can purchase a Medigap policy at any time when 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 certain plan for a period of time before switching to a different plan that they offer. However, you can still get the desired plan from a different company that offers that plan.

聯邦醫療保險補充保險 (Medigap)

聯邦醫療保險補充保險 (Medigap) 是特別為協助獲得原始聯邦醫療保險 A 部分和 B 部分之費用分攤補助而設計。受到聯邦及各州法令管轄，該類保險只能向私營公司購買。您必須有聯邦醫療保險的 A 部分和 B 部分，才能購買醫療補充保險。目前銷售的聯邦醫療保險補充保險保單不包含藥物保險。

為什麼需要醫療補充保險？

醫療補充保險償付聯邦醫療保險中受益人必須自己支付的分攤費用。例如，醫療補充保險可賠付 A 部分的自付額、B 部分核准費用 20% 的門診共保額，以及其他費用。**請注意，有些保險計畫只依百分比賠付這些費用，其他計畫則賠付全額。**已加入聯邦醫療保險優勢計畫的人士不應再參加醫療補充保險計畫，因為這與他們在聯邦醫療保險優勢計畫中所獲得的保障是重複的。

醫療補充保單有那些？

有 10 種標準型 Medigap 醫療補充保單可供選擇，並以英文字母「A」至「N」來標示。每個保單都包含基本福利套件，加上其他福利的組合。1992 年標準化之前的舊式醫療補充保險保單仍然有效，但不能提供予新加入者。持有舊保單者可以轉換新的標準型保單，但不得再恢復持有舊保單。自 2010 年 6 月 1 日起，將不會為新的加入者提供 E、H、I 及 J 計畫，持有 E、H、I 及 J 計畫者可以維持他們的現有承保，但可能希望比較一下賠付與保費成本，以判斷其計畫是否仍具有成本效益。

新項！

在 2020 年 1 月 1 日當日或之後新符合聯邦醫療保險資格的個人，將無法購買醫療補充保險 C 計畫或 F 計畫，包含高自付額的 F 計畫。

何時可以登記加入醫療補充保險？

在紐約州，登記加入聯邦醫療保險之後，隨時都可以購買醫療補充保險。即使年齡在 65 歲以下，並且是因為殘障而取得聯邦醫療保險，也保證有機會可以購買醫療補充保險。

何時可以轉換醫療補充保險？

在紐約州，您隨時可以轉換提供醫療補充保險的公司，以及醫療補充保險的類型。有些公司會要求您必須在某項計畫內維持一段時間，然後才可以轉換至該公司所提供的不同計畫。然而，您仍然可以從提供該計畫的另一家公司取得想要的計畫。

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. Most Medigap insurers have linked their computers with the computers at Medicare, so that your claims can be processed without additional paperwork ("electronic crossover"). Companies can bill the 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 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 need 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 is required to be the same without regard to age, gender or health condition. That means that the premium for Plan N from one insurance company will be the same for a woman, aged 72 in poor health as it will be for a man, aged 81, in good health. A chart of the ten standard plans follows the description of the plans. See page 25 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 a Medigap policy's coverage can be denied for a pre-existing health condition is the first six months of the new policy and only for those claims that are directly related to that condition. A pre-existing condition is a condition for which medical advice was given, or treatment was 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 (1) if you buy a policy during the open enrollment period or (2) if 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 to document that it paid its portion of your claims. Combined with the Medicare Summary Notice (MSN) which you receive from Medicare, you will have the total information about how your health care claim was processed.

如何選擇醫療補充保險保險？
由於醫療補充保險計畫都是標準化形式，首先必須決定您所需要的保障級別。一旦確定何種賠付組合符合您的需要，就可以比較各保險公司的保費、服務和聲譽。大多數醫療補充保險業者都將其電腦與聯邦醫療保險的電腦連線，因此您的理賠申請無需另外進行紙上作業即可處理（「電子跨界」）。保險公司可用月繳、季繳或年繳方式收取保費；您可自行選擇以上付款時間段。

我如何受到保護？
現在售出的所有標準型醫療補充保險保單都保證可以續約。保險公司不得拒絕續約，除非您未繳保費或在申請時資料不實。聯邦法令禁止保險公司或銷售人員賣給您的第二份醫療補充保險保單是與您已有的保障重複，從而保護您免於購買過多不必要保險的壓力。在您需要不同程度的保障時，隨時可以轉換醫療補充保險。例如，當您的醫療需求增加時，如果發現 B 計畫的保障太有限，可以安排購買 G 計畫。新的醫療補充保單將會取代前者。**在新保單生效前切勿取消舊保單。**

如何確定保費額度？
在紐約州，您受到「社區費率」的保障。保險公司為其一項標準型醫療補充保單所設定的每月保費必須相同，不得因年齡、性別或健康狀況而有差異。這表示以一家保險公司 C 計畫的保費而言，72 歲、健康狀況不佳的女性和 81 歲、健康狀況良好的男性將是一樣的。在保險計畫的說明之後附有 10 種標準型計畫的列表。請參閱第 25 頁，以取得適用於紐約市醫療保險受益人的保險公司及其保費清單。

若有加入前已經存在的病況，保險將於何時開始？
醫療補充保單的保障可因加入前已經存在的病況而遭到拒絕，保險公司可以在保險生效的前六個月內拒絕理賠投保前就已經存在的疾病醫療費用，但僅限於與該病況直接相關的理賠要求。加入前已經存在的病況是指在保險生效前的 6 個月內，醫生已針對該病況提供了醫療建議、治療建議，或已接受醫生治療。對於加入前已經存在的病況，您仍然可以有資格享有立即承保，條件是：(1) 若您在開放參加期內購買保險，或 (2) 若您之前加入的醫療保險為期至少 6 個月，且未中斷超過 63 天。若您之前加入醫療保險的時間不到 6 個月，新的醫療補充保單必須按您有保險的月數提供承保。某些保險公司針對已有疾病的等待期較短。加入前已存在病況等候期的圖表可參見網上www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates。

我會從醫療補充保險業公司處收到什麼文件？
醫療補充險保險公司必須寄給您賠付說明，以文件證明其支付了您所提出的醫療理賠要求的部分。加上您從聯邦醫療保險所收到的聯邦醫療保險摘要通知 (MSN)，您將擁有醫療理賠如何處理的全部資訊。

STANDARD MEDIGAP PLANS

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

PLAN A (the basic policy) consists of these **basic benefits:**

- Coverage for the Part A copayment amount ($352 per day in 2020) for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for the Part A copayment amount ($704 per day in 2020) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days.
- 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 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 amount for Part B services (generally 20% of approved amount), after the annual deductible is met ($198 in 2020).

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

- Coverage for the Medicare Part A inpatient hospital deductible ($1,408 per benefit period in 2020).

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

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care copayment amount ($176 per day for days 21 through 100 per benefit period in 2020).
- Coverage of the Medicare Part B deductible ($198 per calendar year in 2020).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible and $50,000 lifetime maximum benefit.

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

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

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

標準型醫療補充保險計畫

以下為 10 種標準型醫療補充保險計畫，計畫 A 至 N，以及每項計畫所提供的賠付：

A 計畫 (基本保單) 含有下列**基本賠付：**

- 在每一段聯邦醫療保險權益期內第 61 至 90 天的住院治療，賠付 A 部分共付額 (2020 年為每天 $352)。
- 對於聯邦醫療保險不可續延的 60 天住院終身儲備期，每一天都提供 A 部分共保額賠付 (2020 年為每天 $704)。
- 在聯邦醫療保險的住院賠付全部用罄之後，對於聯邦醫療保險 A 部分的合格住院支出提供 100% 賠付。在保單持有人的一生中，追加住院治療的賠付上限為 365 天。
- 對聯邦醫療保險 A 部分安寧療護的費用分攤提供賠付。
- 依聯邦醫療保險 A 部分和 B 部分，每一日曆年為最初 3 品脫血液或等量的紅血球濃厚液的合理費用提供賠付，除非是遵從聯邦規定而更換。
- 在達到年度自付額（2020 年為 $198）之後，為 B 部分服務的自付額提供賠付（一般為核准金額之 20%）。

B 計畫包括**基本賠付，另加**

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付 (2020 年每一段權益期為 $1,408)。

C 計畫[1]包括**基本賠付，另加**

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付。
- 對專業護理設施的共付額提供賠付 (2020 年每一段權益期的第 21 天至 100 天為每天$176) 。
- 對聯邦醫療保險 B 部分自付額提供賠付 (2020 年為每日曆年 $198)。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 $250，而一生最高賠付上限為 $50,000。

D 計畫包括**基本賠付，另加**

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付。
- 對專業護理設施的每日共付額提供賠付。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 $250，而一生最高賠付上限為 $50,000。

[1] 2020 年 1 月 1 日以後，C、F 及 F+ 計畫僅提供給在 2020 年 1 月 1 日之前首次符合聯邦醫療保險資格的個人。

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

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- 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 and $50,000 lifetime maximum benefit.

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

- Same benefits as the Standard Plan F, but you will have to pay a $2,340 deductible in 2020 before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums.

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

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

New

PLAN G+ (high deductible)

- Same benefits as the Standard Plan G, but you will have to pay a $2,340 deductible in 2020 before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums. While Plan G does not cover the Part B deductible, the amount that you pay towards the deductible is credited towards the G+ deductible.

Effective June 2010, Medigap policies E, H, I and J are no longer sold to new policyholders. However, individuals who had an E, H, I or J policy prior to June 2010 can keep their policies.

PLAN K[3] includes the **basic benefit, 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% coinsurance for Part B preventive services.
- Coverage for 100% of the Part A copayment amount for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A copayment amount for each of Medicare's 60 non- renewable lifetime hospital inpatient reserve days used.

[2] Plan pays the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

[3] The basic benefits for plans K, L, M and N include similar services as plans A-G, but the cost-sharing for the basic benefits is at different levels. The annual out-of-pocket limit can increase each year for inflation.

F 計畫[1]包括**基本賠付，另加**

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付。
- 對專業護理設施的每日共保額提供賠付。
- 對聯邦醫療保險 B 部分自付額提供賠付。
- 對聯邦醫療保險 B 部分超額費用提供 100% 賠付，也稱為限制收費[2]。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 $250，而一生最高賠付上限為 $50,000。

F+ 計畫[1] **(高自付額)**

- 賠付與標準 F 計畫相同，但是在該計畫支付任何金額之前，2020 年您將必須支付 $2,340 自付額。該金額可能每年提高。高自付額保單的保費較低。

G 計畫包括**基本賠付，另加**

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付。
- 對專業護理設施的每日共付額提供賠付。
- 對聯邦醫療保險 B 部分超額費用提供 100% 賠付，也稱為限制收費[1]。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 $250，而一生最高賠付上限為 $50,000。

新項

G+ 計畫（高自付額）

- 賠付與標準 G 計畫相同，但是在該計畫支付任何金額之前，2020 年您將必須支付 $2,340 自付額。該金額可能每年提高。高自付額保單的保費較低。由於 G 計畫未承保 B 部分自付額，您對該自付額支付的金額將會計入 G+ 自付額。

自 2010 年 6 月起，醫療補充保險的 E、H、I 和 J 計畫不再售予新的保單持有人。不過，在 2010 年 6 月之前即擁有 E、H、I 或 J 計畫保單者仍可保有他們的保單。

K 計畫[3] 包括**基本賠付，另加**

- 對聯邦醫療保險 A 部分住院治療自付額提供 50% 賠付。
- 對 B 部分共保額提供 50% 賠付，唯須先支付聯邦醫療保險 B 部分的年度自付額；不過，B 部分預防性醫療服務的共保額可獲得 100% 賠付。
- 對每一段聯邦醫療保險權益期內住院治療第 61 天至 90 天的 A 部分共付額提供 100% 賠付。
- 對於聯邦醫療保險不可續延的 60 天住院終身儲備期，為耗用之每一天的 A 部分共付額提供 100% 賠付。

[2] 保險計畫會支付聯邦醫療保險核准之 B 部分服務金額與實際費用（最高可達聯邦醫療保險或州法所設定的收費上限金額）之間的差額。

[3] K、L、M 和 N 計畫內的基本賠付與 A 至 G 計畫包括的醫療服務相似，但對基本賠付的分攤費用則屬不同級別。年度自付費用限額可因通貨膨脹而每年調整。

- 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 50% 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 amount.
- Annual out of pocket limit of $5,880 in 2020.

PLAN L[3] includes the **basic benefit, plus**
- Coverage for 75% of 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% coinsurance for Part B preventive services.
- Coverage for 100% of the Part A copayment amount for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A copayment amount for each of Medicare's 60 non-renewable lifetime hospital inpatient 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 amount.
- Annual out of pocket limit of $2,780 in 2020.

Plan M[3] includes the **basic benefit, plus**
- Coverage for 50% of the Medicare Part A inpatient hospital deductible.
- Coverage for 100% of the skilled nursing facility daily copayment amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible and $50,000 lifetime maximum benefit.

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

[3] The basic benefits for plans K, L, M and N include similar services as plans A-G, but the cost-sharing for the basic benefits is at different levels. The annual out-of-pocket limit can increase each year for inflation.

- 在聯邦醫療保險的住院賠付全部用罄之後，對於聯邦醫療保險 A 部分的合格住院支出提供 100% 賠付。在保單持有人的一生中，追加住院治療的賠付上限為 365 天。
- 對安寧療護的費用分攤提供 50% 賠付。
- 對符合聯邦醫療保險條件的最初 3 品脫血液費用提供 50% 賠付。
- 對專業護理設施的每日共付額提供 50% 賠付。
- 2020 年的年度自付費用限額為 $5,880。

L 計畫[3]包括**基本賠付，另加**
- 對聯邦醫療保險 A 部分住院治療自付額提供 75% 賠付。
- 對 B 部分共保額提供 75% 賠付，唯須先支付聯邦醫療保險 B 部分的年度自付額；不過，B 部分預防性醫療服務的共保額可獲得 100% 賠付。
- 對每一段聯邦醫療保險權益期內住院治療第 61 天至 90 天的 A 部分共付額提供 100% 賠付。
- 對於聯邦醫療保險不可續延的 60 天住院終身儲備期，為耗用之每一天的 A 部分共付額提供 100% 賠付。
- 在聯邦醫療保險的住院賠付全部用罄之後，對於聯邦醫療保險 A 部分的合格住院支出提供 100% 賠付。在保單持有人的一生中，追加住院治療的賠付上限為 365 天。
- 對安寧療護的費用分攤提供 75% 賠付。
- 對符合聯邦醫療保險條件的最初 3 品脫血液費用提供 75% 賠付。
- 對專業護理設施的每日共保額提供 75% 賠付。
- 2020 年的年度自付費用限額為 $2,780。

M 計畫[3]包括**基本賠付，另加**
- 對聯邦醫療保險 A 部分住院治療自付額提供 50% 賠付。
- 對專業護理設施的每日共付額提供 100% 賠付。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 $250，而一生最高賠付上限為 $50,000。

N 計畫[3]包括基本賠付，另加
- 對聯邦醫療保險 A 部分住院治療自付額提供 100% 賠付。
- 對聯邦醫療保險 B 部分共保額提供 100% 賠付，唯對於至診所就診的共付額最高賠付上限為 $20，至急診室就診的共付額最高賠付上限為 $50。
- 對專業護理設施的每日共付額提供 100% 賠付。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 $250，而一生最高賠付上限為 $50,000。

[3] K、L、M 和 N 計畫內的基本賠付與 A 至 G 計畫包括的醫療服務相似，但對基本賠付的分攤費用則屬不同級別。年度自付費用限額可因通貨膨脹而每年調整。

BENEFITS INCLUDED IN THE TEN STANDARD MEDICARE SUPPLEMENT PLANS

Basic Benefit: 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 Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit**	Basic Benefit**	Basic Benefit	Basic Benefit**
		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 $5,560	Out of Pocket limit $2,780		

*Plan F and Plan G are also offered with a high deductible option.

**These plans cover the basic benefit but with different cost-sharing requirements.

10 種標準型醫療補充保險計畫所包含的賠付

基本賠付：包含在所有的計畫內

- 住院治療：A 部分共付額，在聯邦醫療保險賠付終止後另提供 365 天賠付，並對 60 天的終身儲備期共付額提供賠付。
- 醫療費用：B 部分共保額（一般為聯邦醫療保險核准費用之 20%）
- 血液：每年的最初 3 品脫血液
- 安寧療護：A 部分的費用分攤。

A	B	C	D	F*	G*	K	L	M	N
基本賠付	基本賠付	基本賠付	基本賠付	基本賠付	基本賠付	基本賠付**	基本賠付**	基本賠付	基本賠付**
		專業護理共保額	專業護理共保額	專業護理共保額	專業護理共保額	專業護理共保額 (50%)	專業護理共保額 (75%)	專業護理共保額	專業護理共保額
	A 部分自付額	A 部分自付額	A 部分自付額	A 部分自付額	A 部分自付額	A 部分自付額 (50%)	A 部分自付額 (75%)	A 部分自付額 (50%)	A 部分自付額
		B 部分自付額		B 部分自付額					
				B 部分超額	B 部分超額				
		國外旅行緊急就醫	國外旅行緊急就醫	國外旅行緊急就醫	國外旅行緊急就醫			國外旅行緊急就醫	國外旅行緊急就醫
						自付費用上限 $5,560	自付費用上限 $2,780		

*F 計畫亦提供高自付額選項可供選擇。

**這些計畫均含基本賠付，但是費用分攤條件互異。

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.

*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 are able to purchase Medigap Plans C, F and F+.

PLAN	Aetna 800-345-6022	Bankers Conseco 800-845-5512	Empire Blue Cross Blue Shield 855-306-9355	Globe Life Insurance* 800-331-2512	GHI 800-444-2333	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 800-523-5800
A	$318.21	$367.70	$179	$240/268	$194.87	$301.72	$333.49	$195	$178.50
B	$362.44	$480.69	$241.11	$330/370	$253.28	$340.60	$512.25	$257	$256.50
C**				$397/444	$300.87	$412.76	$512.82	$304	$320
D				$391/438			$503.90	$280	
F**	$422.90	$648.95	$307.40	$374/419	$530.29	$421.13	$516.15	$306	$308.25
F+**		$75.69		$69/77	$74	$93.09			
G	$406.26	$597.30	$270.14	$348/390	$302	$376.07	$478.04	$281	$270
G+		$75.69		$69/77	$67.69	$92.97			
K		$99.74		$138/154		$196.68		$140	$83.50
L		$286.73		$206/231		$280.85		$208	$173.25
M		$397.13					$526.10	$256	
N		$390.82	$192.22	$259/290		$266.84		$241	$200.25

聯邦醫療補充保險

請直接致電各家公司以瞭解最新每月費率，費率變動恕不另行通知。最新費率表可在紐約州保險局網站查閱，網址為：https://www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates。

*Globe Life Insurance（原為 First United American）保費因郵遞區號而異。使用上述連結來尋找您居住地區的費率。

** 只有在 2020 年 1 月 1 日前符合聯邦醫療保險加入資格的個人，才能購買醫療補充保險 C、F 及 F+計畫。

計畫	Aetna 800-345-6022	Bankers Conseco 800-845-5512	Empire Blue Cross Blue Shield 855-306-9355	Globe Life Insurance* 800-331-2512	GHI 800-444-2333	Humana 800-486-2620	Mutual of Omaha 800-228-9999	TransAmerica Financial 800-752-9797	United Health (AARP) 要登記加入必須為 AARP 會員 (50 歲以上) 800-523-5800 800-523-5800
A	$318.21	$367.70	$179	$240/268	$194.87	$301.72	$333.49	$195	$178.50
B	$362.44	$480.69	$241.11	$330/370	$253.28	$340.60	$512.25	$257	$256.50
C**				$397/444	$300.87	$412.76	$512.82	$304	$320
D				$391/438			$503.90	$280	
F**	$422.90	$648.95	$307.40	$374/419	$530.29	$421.13	$516.15	$306	$308.25
F+**		$75.69		$69/77	$74	$93.09			
G	$406.26	$597.30	$270.14	$348/390	$302	$376.07	$478.04	$281	$270
G+		$75.69		$69/77	$67.69	$92.97			
K		$99.74		$138/154		$196.68		$140	$83.50
L		$286.73		$206/231		$280.85		$208	$173.25
M		$397.13					$526.10	$256	
N		$390.82	$192.22	$259/290		$266.84		$241	$200.25

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 Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPO), HMOs with Point-of-Service option (HMO-POS), and Special Needs Plans (SNP). 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; you must live in the plan's service area; and you cannot have end stage renal disease (ESRD). Beginning in 2021, people with ESRD will also be eligible to join Medicare Advantage plans. A Medicare Advantage plan cannot turn away an applicant because of health problems (or impose a waiting period for pre-existing conditions), other than ESRD.

Joining a Medicare Advantage plan is a choice. Every Medicare Advantage plan must provide its members with all of the same medically-necessary services covered by Part A and Part B of Medicare, and typically include additional services, such as a prescription drug benefit, 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 the needed medical services, to get full information about treatment choices from their doctor, 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.

All MA plans have a network of doctors, health centers, hospitals, skilled nursing facilities and other care providers. Medicare Advantage plans' 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.

聯邦醫療保險優勢計畫
HMO、PPO、HMO-POS、SNP

聯邦醫療保險優勢 (MA) 計畫為受益人提供「原始」聯邦醫療保險之外的選擇。聯邦醫療保險優勢計畫是由民營公司提供，以提供健康維護組織 (HMO)、優選醫療機構計畫 (PPO)、健康維護組織+療點服務 (HMO-POS)、特殊需求計畫 (SNP)。提供聯邦醫療保險計畫的公司會與聯邦醫療保險和醫療補助服務中心 (CMS) 簽訂合約，以向加入者提供聯邦醫療保險福利。

欲符合參加聯邦醫療保險優勢計畫的資格，您必須同時擁有聯邦醫療保險 A 部分和 B 部分；必須居住在該計畫的服務地區；並且不能患有末期腎臟疾病 (ESRD)。自 2021 年開始，罹患 ESRD 的人也有資格加入聯邦醫療保險優勢計畫。聯邦醫療保險優勢計畫不得因 ESRD 以外的健康問題（或是對加入前已經存在的病況設定等候期）而拒絕申請人加入。

可以選擇加入聯邦醫療保險優勢計畫。每項聯邦醫療保險優勢計畫都必須提供與聯邦醫療保險 A 部分和 B 部分所承保之相同的必要醫療服務予其會員，並且可能含有更多服務，例如處方藥保險、眼科、牙科及聽力醫療服務。若您希望有聯邦醫療保險 **D 部分處方藥保險**，並且已加入聯邦醫療保險優勢計畫，您必須透過該計畫取得 D 部分藥品保險；您無法加入個別的 D 部分計畫。所有的聯邦醫療保險受益人都有權利取得所需的醫療服務、從醫生處獲得關於治療選擇的充分資訊，並且就聯邦醫療保險優勢計畫所駁回的任何服務或償款提出申訴。

如果您加入醫療保險優勢計畫，則**不能**購買醫療補充保險，因為這可能造成重複保險。

聯邦醫療保險優勢計畫的每位會員在加入過程中都必須收到一份保險賠付摘要。其中必須明列關於追加保費、例行程序、緊急醫療服務的取得與通報要求，以及醫療服務的共付額等重要資訊。該計畫還會提供醫療業者名錄、參與計畫的藥房，以及保險賠付的藥物及費用計算清單。

所有 MA 計畫都是由醫生、健康中心、醫院、專業護理設施和其他醫療護理提供者構成的網路。聯邦醫療保險優勢計畫的網路可以是當地的、全州、甚至全國性的。實際聯絡該計畫以瞭解醫療業者網路的區域範圍是很重要的，尤其是當您出外旅行而可能會在您居住以外的地區接受非緊急性的醫療護理時更是如此。

HMOs require the Medicare beneficiary to select a primary care physician (PCP) from the HMO's network of local doctors. You have a choice of physician, provided he or she has availability for new patients. Some HMOs require that the PCP provide a referral to specialists. You must receive your health care from the HMO's network of providers and hospitals. Except for emergency care, there is no coverage for services obtained out-of-network; the beneficiary will be responsible for the full costs of such services.

PPOs provide a network of health care providers and hospitals but do not restrict the enrollee from going out-of-network. The PPO sets its payment to in-network providers with a fixed co-pay from the enrollee; 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 with Point-Of-Service Option **(HMO-POS)** is similar to a PPO plan. It provides greater flexibility than an HMO because members may use both in-network and out-of-network providers. However, HMO-POS plans may not cover all benefits out-of-network. For example, a plan may only offer in-network inpatient hospital coverage. Contact the plan for details.

Special Needs Plans (SNP) are Medicare Advantage plans that are available only to certain groups of people with Medicare. Examples of people who might be eligible to join a Medicare Advantage SNP include: people with both Medicare and Medicaid; people with certain chronic conditions; and people living in an institution, such as a nursing home. Coverage includes services covered by Medicare Parts A and B, as well as Part D prescription drug coverage. SNPs may also provide additional services that may be needed by the specific population to which they are geared. Eligible people with Medicare can join a SNP at any time.

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

Enrolling in a Medicare Advantage Plan when first Medicare eligible can be done during the Initial Coverage Election Period (ICEP). Enrollment can be done online at www.medicare.gov, by calling 1-800-MEDICARE, or by contacting the plan directly.

- For most people, the ICEP is the 7-months surrounding the month in which you are first Medicare eligible. Your plan will be effective the first month of Medicare eligibility, or the month following the month of enrollment.
- Beneficiaries that delay Part B enrollment will have their ICEP extended to allow them to enroll in a MA plan.

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

HMO 要求 聯邦醫療保險受益人從 HMO 的當地醫生網路中選擇一位主理醫生 (PCP)。您可以選擇醫生，前提是該醫生願意接受新病人。一些 HMO 要求 PCP 提供轉診至專科醫師的服務。您必須從醫療服務提供者及醫院的 HMO 網路取得醫療護理。除急診治療外，對於在非網內所取得的醫療服務不提供賠付；受益人須自行負擔這類服務的全額費用。

PPO 提供由醫療護理業者及醫院所組成的網路，但是並不限制會員尋求非網內的醫療服務。PPO 有對網內的醫療業者賠付作設定，要求會員支付固定的共付額；對於非網內的醫療業者所提供的服務，會員則必須支付較高費用。（非網內業者須受到聯邦醫療保險收費限制的約束，限制業者能向聯邦醫療保險受益人收取醫療服務費用的金額。）

含健康維護組織療點服務之 **HMO** (**HMO-POS**) 與 PPO 計畫類似。與 HMO 相比較，HMO-POS 更有靈活性，會員可以使用網內及非網內的醫療業者。但是，HMO-POS 計畫並不包含非網內所有福利。例如，一項計畫可能僅會提供網內住院保險。請聯絡計畫以瞭解詳情。

特殊需求計畫 (SNP) 是僅提供予擁有聯邦醫療保險之特定族群的聯邦醫療保險優勢計畫。可能有資格加入聯邦醫療保險優勢計畫 SNP 的人士包括：同時擁有聯邦醫療保險和醫療補助的人士、患有某些慢性病症的人士，以及住在療養院之類機構的人士。保障包含由聯邦醫療保險 A 部分、B 部分以及 D 部分處方藥保險提供賠付的服務。SNP 還可能提供更多針對某類特定人士所需而設定的服務。符合資格並擁有聯邦醫療保險的人士可以隨時加入 SNP。

聯邦醫療保險優勢計畫的詳細列表請見美國政府出版物政府出版物「Medicare and You Handbook」（聯邦醫療保險與您手冊）。計畫詳情請瀏覽網站 www.medicare.gov 或致電 1-800-MEDICARE。

若在初級保障選擇期間 (ICEP) 第一次符合聯邦醫療保險資格，則可**登記加入聯邦醫療保險優勢計畫**。可透過造訪 www.medicare.gov、撥打 1-800-MEDICARE 或直接聯絡計畫，即可在線上登記加入。

- 對於大多數的人而言，ICEP 是您第一次符合聯邦醫療保險之月份的前後 7 個月。您的計畫將自符合聯邦醫療保險資格的第一個月，或是登記加入當月後一個月生效。
- 延遲登記加入 B 部分的受益人可延長其 ICEP，以便登記加入 MA 計畫。

第一次符合聯邦醫療保險資格（在其 ICEP 期間）登記加入 MA 計畫的人有**開放參加期**，這讓他們自第一次符合聯邦醫療保險資格時有三個月的時間，可以決定要變更為不同的 MA 計畫，或是回到聯邦醫療保險原始計畫（無論是否有 D 部分計畫）。

In addition, the Open Enrollment period is also open to all beneficiaries in MA plans at the beginning of the year, from January 1 – March 31. They can switch to a different Medicare Advantage plan or return 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, simply enroll in the plan in which you want to enroll; this enrollment will automatically disenroll you from the other 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 their 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-December 7, you can change your Medicare Advantage (MA) plan or return to Original Medicare, with the change effective January 1.

Special Enrollment Period (SEP): Individuals with Medicaid, a Medicare Savings Program or Extra Help can switch plans once a 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 change to either a different Medicare Advantage plan or to Original Medicare 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 cancel your supplemental coverage.

Medicare Advantage Appeals

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 for denials for prescription drugs. Pay attention to the time limit for filing appeals.

此外，開放參加期也從年初（1 月 1 日至 3 月 31 日）開放給 MA 計畫的所有受益人。他們可以轉到不同的聯邦醫療保險優勢計畫或轉回聯邦醫療保險原始計畫，而自次月首日開始生效，亦即 2 月 1 日、3 月 1 日或 4 月 1 日。若要進行此項變更，只要登記加入您想要加入的計畫，這個登記加入行為便會讓您自動退出其他聯邦醫療保險優勢計畫。

SEP65 是適合因為年齡（而非殘疾）而符合聯邦醫療保險資格的人的特定參加期，他們可以在其初級保障選擇期間 (ICEP)，亦即其 65 歲生日當月份來登記加入 MA 計畫。這讓他們自 MA 計畫生效起有 12 個月的時間，可以選擇變更為聯邦醫療保險原始計畫（而非其他 MA 計畫）。

年度選擇期間 (AEP)：從 10 月 15 日至 12 月 7 日，您可以更改聯邦醫療保險優勢計畫 (MA)，或是回到聯邦醫療保險原始計畫，變更將從 1 月 1 日起生效。

特定參加期 (SEP)：已登記加入醫療補助、聯邦醫療保險免保費計畫或額外補助的人士可以在當年度的前 9 個月（1 月至 3 月；4 月至 6 月；7 月至 9 月）期間每季轉換計畫一次，而且變更會在下個月 1 日生效。個人可以變更為不同聯邦醫療保險優勢計畫或是包含 D 部分計畫的聯邦醫療保險原始計畫。

轉換聯邦醫療保險原始計畫及聯邦醫療保險優勢計畫的提示

- 從聯邦醫療保險優勢計畫變更為聯邦醫療保險原始計畫：選擇並參與一項 D 部分計畫，同時此計畫與聯邦醫療保險原始計畫相通（這將會促使 MA 計畫的自動退出）。考慮補充類的保險，例如醫療補充保險。
- 從聯邦醫療保險優勢計畫變更為聯邦醫療保險優勢計畫：參與大家都想要的聯邦醫療保險優勢計畫（這將會促使從原本 MA 計畫的自動退出）。
- 從聯邦醫療保險原始計畫變更為聯邦醫療保險優勢計畫：參與大家都想要的聯邦醫療保險優勢計畫（這將會促使您自動退出與原始型互通的 D 部分計畫）。您可能會希望取消補充類的保險。

聯邦醫療保險優勢計畫申訴

保險計畫不提供或拒絕賠付醫療服務的決定是由該計畫的理賠部門處理。依據您是否尚未接受服務、已經接受服務或處方藥遭駁回，聯邦醫療保險優勢計畫加入者的申訴程序會有所不同。請留意提出申訴的時間限制。

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

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

Appeals for prescription drug coverage works the same for people in Original Medicare or a Medicare Advantage plan. See page 35 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 too soon, call Livanta at 1-877-588–1123 (TTY: 1-855- 887-6668). If you request an immediate review by Livanta, you will not be financially responsible for additional hospital charges until noon of the day following your receipt of Livanta's review decision.

在接受服務或項目之前，健康服務或項目保障遭到駁回的聯邦醫療保險優勢計畫加入者不可要求計畫重新考慮其決定。請依照「醫療保障遭駁回通知」 (Notice of Denial of Medical Coverage) 上的步驟，針對此決定提出申訴。

如果聯邦醫療保險優勢計畫駁回其已經接受的健康服務或項目的保障，您可以選擇提出申訴，要求您的計畫重新考量其決定。請依照「賠付說明」 (Explanation of Benefits) 或「拒絕付款通知」 (Notice of Denial of Payment) 上的步驟。

對於始聯邦醫療保險或聯邦醫療保險優勢計畫的加入者，處方藥保障的申訴程序完全相同。請參閱第 35 頁以了解 D 部分保障申訴資訊。

若有護理品質投訴或若覺得聯邦醫療保險 A 或 B 部分服務太早結束，以致於讓患者太早出院，請致電 Livanta：1-877-588-1123 (TTY：1-855- 887-6668)。若是請求 Livanta 立即進行審查，在收到 Livanta 審查決定的次日中午之前，都無須負擔任何額外的住院費用。

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 schedule. 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, co-insurance and deductibles for health services. Make sure you understand the different out-of-pocket costs for a primary care visit, a specialist visit, inpatient hospital stays, prescription drugs, and other fees you may have to pay.**

All Medicare Advantage plans are required to have annual maximum out-of-pocket costs for all Part A and Part B covered services, which limits how much you will have to pay out-of-pocket in a given calendar year. In 2020, maximum out-of-pocket costs (MOOP) cannot exceed $6,700 in-network for HMO plans and $10,000 combined in-network and out-of-network for PPO plans.

What about emergency services?
Emergency medical care will be covered by the 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 the need for care does 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 Quality Improvement Organization (QIO), Livanta, LLC, 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.

Obtaining Services in Original Medicare vs. Medicare Advantage
In Original Medicare, the beneficiary obtains all 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 19), can cover all or most of the beneficiary's share of the costs. Medicare Advantage plans are managed care plans, and operate differently, with their own cost structure that can include premiums, deductibles, co-payments and maximum out-of-pocket costs.

關於聯邦醫療保險優勢計畫的常見問題

在聯邦醫療保險優勢計畫中的自付費用為何？
每項聯邦醫療保險優勢計畫會設定其各自的保費和費用分攤方案。除了每月聯邦醫療保險 B 部分保費之外，您可以用月保費的方式另外直接付予該計畫。所有的費用分攤規定都必須在您的保險卡上或保險賠付摘要中清楚說明。若有不確定之處，請致電該計畫。**保健服務可能會有共付額、共保額及自付額。確保您理解主理醫生訪視、專科醫生訪視、住院病人住院、處方藥的不同自付費用以及您可能得支付的其他費用。**

對於 A 部分和 B 部分所承保的全部服務，所有的聯邦醫療保險優勢計畫都需要有每年自付費用的最高限，對您在每一日曆年所需負擔的自付費用設定限額。2020 年，HMO 計畫網路內的自付費用最高限 (MOOP) 不得超過 $6,700，而 PPO 計畫結合網內及非網內的最高限為 $10,000。

對急診服務的保障如何？
只要遵照通報規定並獲得核准，緊急醫療護理將能得到聯邦醫療保險優勢計畫的賠付。您可能需要先支付費用給醫療機構，然後再向該計畫申請理賠償款。若該計畫判定醫療護理需求不符合其條件，或是通報不實，則可能拒絕賠付該費用。

我該如何對醫護品質提出投訴？
若投訴是關於您所受到的醫護品質應該遵照您的保險計畫的陳情程序。您也可向聯邦醫療保險品質改善組織 (QIO) ，在紐約州為 Livanta, LLC 提交您的個案，Livanta 的醫生及其他專業人士會審為聯邦醫療保險病人所提供的醫療護理。可致電 1-866-815-5440 聯絡 Livanta。

聯邦醫療保險原始計畫與聯邦醫療保險優勢計畫所獲得服務之比較
聯邦醫療保險原始計畫可讓受益人從美國各地的任何聯邦醫療保險機構取得所有必要的醫療服務。聯邦醫療保險為這些服務設定收費，並且對大部分費用提供 80% 賠付。受益人須支付餘額。聯邦醫療保險補充保險亦即 Medigap（請見第 19 頁），可為受益人所分攤的費用提供全額或大部分賠付。聯邦醫療保險優勢計畫是管理式護理計畫，而且運作方式有所不同，其本身的成本結構可能包含保費、自付額、共付額及自付費用的最高限。

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

Consideration should be given to the following areas before joining a plan: Your current doctors' participation in the plan; hospitals' participation in the plan; prescription drug coverage; finances; and geographical location. 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 particular plan. Even if you already have an established relationship with that doctor, you need to be certain that they will accept you as a new patient under that particular plan. Confirm provider participation each year.
2. **Preferred hospital(s) 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 the hospital on an out-of-network basis.
3. **Prescription drugs:** Check how the plan would cover your prescription drugs (formulary, restrictions, cost) by using the Medicare.gov Planfinder (see page 34).
4. **Finances:** Receiving care through a Medicare Advantage plan may cost you less than receiving care through Original Medicare. Medicare Advantage plans may cover services which are not covered by original Medicare, such as routine vision and dental care, as well as hearing aids. It is important to research the fee structure (premium, copays, deductible, maximum out-of-pocket costs, etc.) in a Medicare Advantage plan before enrolling.
5. **Geographical Location:** It is important to think about your travel plans when deciding whether an HMO plan is right for you. Because HMO plans have defined geographic areas that they serve, if you plan to be outside of the service area for any length of time, an HMO may not be right for you, since only emergency care is covered outside the plan's service area. The service areas of PPO and HMO-POS plans are less restrictive, but you should still be aware of the plan's service area.
6. **Star ratings:** Every plan has a star rating that reflects indicators 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 for at least 30 days, until you see 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 19.

我該如何決定應否加入聯邦醫療保險優勢計畫及哪項計畫可能適合我？

在加入計畫之前，應該先考慮以下方面：您的現任醫生對該計畫的參與、醫院對該計畫的參與、處方藥物保障、財務狀況以及地理位置。重要的是在年度選擇期間（10 月 15 日至 12 月 7 日）內，每年檢視此資訊。

1. **您的醫生對該計畫的參與**：查詢您的醫生是參加何種計畫，以及他們是否接受該特定計畫之下的聯邦醫療保險新病人。即便您原來是至該醫生處就診，仍必須確定他們將以該特定保險計畫的新病人身份向您提供服務。每年確認醫療服務提供者的參與情況。
2. **首選醫院參與該計畫**：確保您使用以及您希望造訪的任何醫院參與該計畫、或將會允許您在網路以外的基礎上對其進行造訪。
3. **處方藥**：使用 Medicare.gov 計畫搜尋工具（請參閱第 34 頁）檢查該計畫將會如何承保您的處方藥（處方集、限制、費用）。
4. **財務狀況**：經由聯邦醫療保險優勢計畫取得醫療護理的費用，可能低於透過聯邦醫療保險原始計畫取得醫療護理。聯邦醫療保險優勢計畫可能承保聯邦醫療保險原始計畫所不承保的服務項目，例如：例行的眼科和牙科護理，以及助聽器。重要的是要在登記加入之前研究聯邦醫療保險優勢計畫的費用結構（保費、共付額、自付額、自付費用的最高限等）。
5. **地理位置**：在決定 HMO 計畫是否符合所需時，把旅行計畫列入考慮是很重要的。由於 HMO 計畫已界定提供服務的地理區域，若是打算在服務區域以外的地點停留，不論多久時間，HMO 可能都不適合您，因為在該計畫的服務區域以外，僅有緊急醫護可獲保險賠付。PPO 和 HMO-POS 計畫的服務區域限制較少，但您仍應留意該計畫的服務區域。
6. **星級評等**：每個計畫都有星級評等，可反映聯邦醫療保險衡量的指標。

未來我是否還需要聯邦醫療保險補充保險？

若是加入聯邦醫療保險優勢計畫，將不需要聯邦醫療保險補充保險 (Medigap)，因為補充保險僅在您使用聯邦醫療保險原始計畫時有用。若是決定加入聯邦醫療保險優勢計畫，而您已經擁有聯邦醫療保險補充保險，則可以將其保留至少 30 天，直到您確定聯邦醫療保險優勢計畫令人滿意。根據紐約州法律，只要是退出聯邦醫療保險優勢計畫並回到聯邦醫療保險原始計畫，隨時都可以購買醫療補充保險，不過若您有保障空窗期，則可能會面臨一段時間對已有的病症沒有保險。關於醫療補充保險的詳細資訊，請參閱第 19 頁。

MEDICARE PART D – PRESCRIPTION DRUG COVERAGE

Medicare Part D is prescription drug coverage offered through private insurance companies to help cover 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 only offered through private companies who have entered into a contract 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 for getting a new drug covered or appealing to have a medication covered to meet your special needs.

Medicare Part D is offered in one of two ways:

1. **Stand Alone Prescription Drug Plans (PDPs):** these plans work with Original Medicare and ONLY cover prescription drugs.
2. **Medicare Advantage Prescription Drug Plans (MAPDs):** these are managed care plans, such as HMOs, PPOs, HMO-POS, or SNPs, which offer comprehensive benefits packages that cover all of 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 Part D coverage 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 have to pay (premium, deductible, copays), and which pharmacies you can use (network). All drug plans have to provide at least a standard level of coverage, which Medicare sets. However, some plans offer enhanced benefits and may charge a higher monthly premium. When a beneficiary joins a drug plan, it is important to choose one that meets the individual's prescription drug needs.

Beneficiaries with higher incomes (above $87,000 for an individual or $174,000 for a couple) will pay a surcharge for Part D in addition to their plan premium. The surcharge ranges from $12.20 to $76.40 per month in 2020, and is paid in the same way as the Part B premium, typically as a deduction from one's Social Security check (see page 64 for rate chart).

Although Part D plans' benefit designs vary, they each include the following minimum levels of coverage in 2020:

- **Deductible** (up to $435). This is the amount that you have to pay out-of-pocket before your plan helps pays for the cost of your drugs. Some plans have a lower deductible or no deductible.

聯邦醫療保險 D 部分 – 處方藥保險

處方藥保險聯邦醫療保險 D 部分是透過私營保險公司提供的處方藥保險計畫，以協助支付處方藥費用。

聯邦醫療保險處方藥計畫適用於所有擁有聯邦醫療保險（A 部分和/或 B 部分）的人士。D 部分是選擇性並且自動生效的保險賠付；聯邦醫療保險受益人無須強制加入計畫，不過延遲登記可能會有處罰措施。

聯邦醫療保險 D 部分只能透過私營公司提供，這些計畫會以與聯邦政府訂立契約的形式，為聯邦醫療保險受益人提供聯邦醫療保險 D 部分處方藥保險。聯邦醫療保險和醫療補助服務中心 (CMS) 負責監管保險計畫和承保藥品的類別。每個 D 部分都有自訂的承保藥品（處方藥）及參與藥房列表，也有自己的作業程序以將新藥納入保險賠付，或是就藥物的承保提出申訴以滿足您的特殊需要。

聯邦醫療保險 D 部分以兩種方式提供：

1. **單獨的處方藥保險計畫 (PDP)**：這些保險計畫會與聯邦醫療保險原始計畫合作，而且只承保處方藥。
2. **聯邦醫療保險優勢處方藥計畫 (MAPD)**：這些是管理式醫療計畫，例如：HMOs、PPOs、HMO-POS、或 SNPs，提供綜合賠付套裝計畫，保障涵蓋以下各項：醫院、醫生、專科醫生、藥房和處方藥。若是已加入聯邦醫療保險優勢計畫，並且希望擁有 D 部分的承保內容，您必須透過聯邦醫療保險優勢計畫取得 D 部分保險。

選擇加入 D 部分計畫者將須繳交月保費，並分攤部分處方藥費用。各家藥品保險計畫所承保的處方藥種類（處方集）、自行付費額度（保費、自付額、共付額）及可以使用的藥房都有差異。所有的藥品計畫至少都必須提供由聯邦醫療保險所設定的基本保障。然而，有些計畫會提供升級的保險賠付，並且可能收取較高的月保費。受益人參加藥品計畫時，選擇能夠符合個人處方藥需求的計畫很重要。

較高收入的受益人（個人收入在 $87,000 以上或夫妻收入在 $174,000 以上）除了繳交保險計畫的月保費之外，還要為 D 部分支付附加費。附加費從每月 $12.20 至 $76.40 不等，並且得以用繳交 B 部分保費的相同方式支付，通常是從個人的社會安全福利金支票中扣除（請見第 64 頁的費率表）。

雖然 D 部分計畫的保險賠付設計各異，但在 2020 年每項計畫都包含下列最起碼的承保內容：

- **自付額**（最高至 $435）。在您的計畫幫助支付藥物費用之前，這就是您自付金額。有些計畫的自付額較低或無需自付額。

- **Initial Coverage Level**. You pay a fixed copay of up to 25% of drug costs up to $4,020 in total drug costs. (Total drug costs include the amount that you pay for the drug plus the amount that the plan pays for the drug.)
- **Coverage Gap**. After $4,020 in total drug costs, you pay 25% of brand name and generic drug cost (plus a nominal pharmacy dispensing fee), until **you** have incurred $6,350 in out-of-pocket costs. This includes the deductible (if any) plus any co-payments or coinsurance paid while reaching the coverage gap, the entire 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 $6,350 in out-of-pocket expenses). The beneficiary is responsible for the greater of five percent (5%) of drug costs or a copay of $3.60 for generic medications and $8.95 for brand-name drugs.

Enrollment in Medicare Part D

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

Enrollment in Part D can occur during one's seven-month Initial Enrollment Period (IEP), (see page 5). In addition, a beneficiary may join or change plans once each year between October 15 and December 7, during the Annual Election Period (AEP).

There are also limited exceptions where a beneficiary would be granted 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 Medicaid, a Medicare Savings Program or Extra Help can switch plans once a 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 in a calendar year (see page 38).
- Between January 1 – March 31, if you are in a Medicare Advantage plan with Part D, you can make a change to either a different Medicare Advantage plan, or to Original Medicare with or without Part D drug coverage.
- Change in county of residence where one has new Part D plan choices. (This SEP also includes individuals returning to the USA after living abroad and those released from prison.)
- Individuals entering, residing in, or leaving a long-term care facility, including skilled nursing facilities.
- Individuals disenrolling from employer/union-sponsored coverage, including COBRA, to enroll in a Part D plan.
- Prescription drug plan withdrawal from service area.

- **初級保障**。固定共付額為藥費的 25%，總藥費最高為 $4,020。（藥品費用總額包括自付的藥品費用金額加上該計畫支付的藥品費用金額。）
- **保障缺口**。藥品費用總額達到 $4,020 之後，您支付 25% 的原廠品牌藥費用和非原廠等同藥費用（加上名義藥局調配費），直到**您**自付費用達到 $6,350 為止。此包括自付額（如有） 加上即將達到保險缺口時的任何共付額或共保額，在保險缺口期間購買原廠品牌藥的全部費用，以及在保險缺口期間購買非原廠等同藥的自付費用。
- **重大傷病賠付**（自付費用達 $6,350 之後）。受益人須自行負擔以下金額較大者：5% 的藥品費用，或 $3.60 的非原廠等同藥共付額及 $8.95 的原廠品牌藥共付額。

登記加入聯邦醫療保險 D 部分

登記加入聯邦醫療保險處方藥保險需要選擇提供與聯邦醫療保險原始計畫合作的 D 部分計畫 (PDP) 或聯邦醫療保險優勢處方藥計畫 (MA-PD)。可上網查閱兩者的比較：www.medicare.gov 或致電 1-800-MEDICARE。您也可以聯絡 HIICAP 尋求協助。

可在 7 個月的首次參加期 (IEP) 期間登記加入 D 部分（請見第 5 頁）。此外，在每年 10 月 15 日至 12 月 7 日的年度選擇期 (AEP) 期間，受益人可以加入或更改計畫一次。

受益人也可能獲准在年度協調選擇期之外的**特定參加期 (SEP)** 登記加入 D 部分計畫或轉換計畫，此為極有限的例外情況。其中包括以下情況：

- 已登記加入醫療補助、聯邦醫療保險免保費計畫或額外補助的人士可以在當年度的前 9 個月（1 月至 3 月；4 月至 6 月；7 月至 9 月）期間每季轉換計畫一次，而且變更會在下個月 1 日生效。
- EPIC 會員在日曆年內可更改 D 部分計畫一次（請參閱第 38 頁）。
- 在 1 月 1 日至 3 月 31 日期間，如果您已登記加入包含 D 部分的聯邦醫療保險優勢計畫，則可以變更為不同的聯邦醫療保險優勢計畫，或是轉換至包含或不包含 D 部分藥品保險的聯邦醫療保險原始計畫。
- 改變居住的郡縣而得以選擇新的 D 部分計畫。（此特殊參加期也包括在國外居住後又回到美國者和出獄者。）
- 入住、居住或離開長期護理設施者，包括專業護理設施。
- 退出雇主/工會所提供之保險（包括 COBRA），以登記參加 D 部分計畫。
- 處方藥計畫撤出服務地區。

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 if a person with Medicare does not currently use a lot of prescription drugs, he or she should still consider purchasing a Part D plan. If a beneficiary does 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 one percent (1%) of the "base premium" ($32.74 in 2020) per full month that the person with Medicare was not enrolled in a Medicare prescription drug plan when first eligible, and did not have creditable coverage. This penalty needs to be paid for as long as you have Part D coverage. If the beneficiary has had creditable coverage with a gap of no more than 63 days from when that coverage ended and the Medicare Part D coverage begins, they will not be subject to a penalty. There is no late enrollment penalty for people with full or partial Extra Help (see page 36).
- Anyone who enrolls in Part D during their Initial Enrollment Period (IEP) will not incur a late enrollment penalty. Other people with creditable coverage, such as through a former employer or union, the Veterans Administration (VA), or TRICARE for Life, will not experience a penalty for late enrollment.

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 through a current or former employer. The current or former employer should advise you, usually through a letter, as to whether your drug coverage is "creditable" and whether or not you should enroll in a Part D plan. If you do not receive a letter, contact the employer to determine if you should enroll in a Part D plan. <u>This is vital, since enrollment in a Part D plan may compromise **all** health benefits through that employer, not just prescription drug coverage.</u>

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

Having Part D coverage is optional, though it is important to remember that most people can only sign up for a plan during the Annual Election Period (AEP), from October 15 - December 7 of each year. It may be advisable to explore the least expensive plan in case your drug needs change in the coming year. <u>You may face a late enrollment penalty if you do not enroll when you are first eligible.</u>

How do I select a Part D plan?

To select a Part D plan, it is best to use the Planfinder 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.

申請加入聯邦醫療保險 D 部分計畫有幾種方式：

- 可造訪 www.medicare.gov 或保險計畫的網站。
- 以電話申請，可致電 1-800-MEDICARE 或直接致電該計畫。
- 親自申請，於預訂的家庭訪問期間，透過 D 部分計畫的代表申請。

延遲登記罰金

- 即使擁有聯邦醫療保險者目前很少用到處方藥，他們仍應該考慮購買 D 部分計畫。若受益人沒有可信的藥品保險（保障至少與標準的聯邦醫療保險處方藥保障相當），而他們選擇延後加入，則必須支付延遲登記罰金。在首次合格時擁有聯邦醫療保險者未登記加入聯邦醫療保險處方藥計畫，也沒有可信的保險，其每月罰金相當於「基本保費」（2020 年為 $32.74）的百分之一 (1%)。只要擁有 D 部分保險就必須支付此項罰金。若受益人擁有可信的保險，而在該保險終止與聯邦醫療保險 D 部分保險開始時的缺口少於 63 天，即無須繳交罰金。領取全額或部分額外補助的人士也無延遲登記罰金（請參閱第 36 頁）。
- 凡是在首次參加期 (IEP) 期間登記加入 D 部分計畫者，將不會有延遲登記罰金。其他擁有可信保險的人士，例如透過前雇主或工會、退伍軍人事務部 (VA) 或軍人醫療保險 (TRICARE for Life)，將不會因為延後加入而面臨懲罰。

若是已有雇主健康保險，是否需要 D 部分計畫？

若透過現在或以前的雇主而擁有可信的藥品保險，可能不需要加入 D 部分計畫。現在或以前的雇主應該會告知（通常是以信函方式）您的藥品保險是否「可信」，以及您是否應該加入 D 部分計畫。若未收到此一信函，請聯絡雇主以決定您是否應該登記加入 D 部分計畫。<u>這一點至關重要，因為登記加入 D 部分可能使透過該雇主所擁有的**所有**健康福利失效，並非僅是處方藥保險。</u>

我若是未服用任何藥物，還需要 D 部分計畫嗎？

D 部分承保範圍是選擇性的，但很重要的的是必須牢記，大多數人只能在年度協調選擇期 (AEP) 期間登記加入計畫，此為每年 10 月 15 日至 12 月 7 日。建議不妨找出最便宜的計畫，以備來年的藥物需求有所變動。<u>若未在首次合格時登記加入，可能會面臨延遲加入的懲罰措施。</u>

如何選擇 D 部分保險計畫？

欲選擇 D 部分保險計畫，最好是前往 www.medicare.gov 使用計畫搜尋工具。您可以使用聯邦醫療保險帳戶使用者名稱及密碼進行登入，或是在您未輸入識別資訊的地方進行一般搜尋。

Follow the Planfinder prompts so all of the medications you are currently taking or expect to take in the upcoming year, along with the dosages and quantities needed are correct. It is best to ask for a listing of your medications from your pharmacist before you start this process.

You will be asked to select up to three pharmacies that you would like to include in your search. After you have input all of the information, the plan finder will allow you to select which 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 advised to call up the plan 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. HIICAP counselors are able to assist you with using the Planfinder.

Cost utilization management tools
In an effort to control costs, Medicare prescription drug plans employ the following cost utilization management tools – Tiers, Prior Authorization, Step Therapy, and Quantity Limits.

- **Tiers:** Part D plans divide their formulary (list of covered medications) into "tiers" and encourage the use of drugs covered under a lower tier by assigning different co-payments or coinsurance for the different tiers. Generally, generic drugs fall under a lower tier and cost less than drugs covered under a higher tier, such as brand-name medications.
- **Prior Authorization:** Although a plan may cover a medication in its formulary, they may require that a doctor contact the plan to explain the medical necessity for that particular drug.
- **Step Therapy**: A Part D plan may require a beneficiary to try less expensive drugs for the same condition before they will pay for a more expensive, brand name medication. However, if a beneficiary has already tried the less expensive drugs they should speak to their doctor about requesting an exception from the plan.
- **Quantity Limits:** For safety and cost reasons, plans may limit the quantity of drugs that they cover over a certain period of time. For instance, a plan may only cover up to a 30-day supply of a drug at a time.

Part D Appeals
Part D appeals follow the same process regardless of whether you have coverage in 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 price than you think you should pay, you can:

- ➢ Speak to your prescriber to see if there's another medication that the plan would cover.
- ➢ Ask the plan to grant an "Exception" to cover your medication, or to cover your medication at lower cost sharing.
- ➢ If you disagree with your plan's decision, you can file an appeal by following the directions on the plan's denial notice. Pay attention to the time limit for filing appeals.

依照計畫搜尋工具指示，使您目前正在服用的藥物名稱，或是來年預期將服用的藥物名稱，以及劑量和總量都正確顯示。在開始此項程序之前，最好先向藥劑師索取一份您的用藥清單。

過程中會要求您選擇至多三家藥房納入搜尋。在您輸入所有資訊之後，計畫搜尋器便可讓您選取您想要檢視的計畫──可能是與聯邦醫療保險原始計畫搭配的 D 部分計畫，或是聯邦醫療保險優勢計畫。您可以使用各種工具以篩選搜尋結果。仔細看每項計畫的細節以瞭解有無適用任何限制非常重要。同時也建議您致電該計畫以確認其資訊。

當您選妥適合自己的計畫之後，可以上網登記或是致電聯邦醫療保險 (1-800-MEDICARE) 或 D 部分計畫。HIICAP 輔導員可協助您使用計畫搜尋工具。

成本利用管理工具
為了控制成本，聯邦醫療保險處方藥計畫運用下列成本利用管理工具 ─ 藥品分級、事前授權、循序用藥及數量限制。

- **藥品分級**：大部分的 D 部分計畫都把藥物及費用計算清單（承保的藥品列表）劃分「等級」，並以不同等級的藥品有不同的共付額或共保額的方式，鼓勵使用較低等級的承保藥品。與原廠品牌藥之類較高等級的承保藥物相比，非原廠等同藥通常屬於較低等級且成本較低。
- **事前授權**：雖然保險計畫可能承保其藥物及費用計算清單的藥品，仍可能會要求醫生與該計畫聯絡，以說明使用該特殊藥物的醫療必要性。
- **循序用藥**：D 部分計畫可能要求受益人先試用較便宜的藥品以治療同一病症之後，他們才會支付較昂貴的原廠品牌藥。不過，若受益人已經試過較便宜的藥品，他們應該與醫生討論對該計畫提出破例要求。
- **數量限制**：基於安全與成本因素，保險計畫可能會對在一定期間內賠付的藥品數量加以限制。例如，保險計畫對於一種藥品的賠付可能一次最多為 30 天用量。

D 部分申訴
無論您是否有單行的 D 部分 (PDP) 或聯邦醫療保險優勢計畫 (MA) 的保障，D 部分申訴的執行程序都相同。如果計畫未承保您認為您有需要的藥物，或是計畫雖然承保該藥物，但價格卻遠高於您能負擔的價格，您可以：

- ➢ 諮詢您的開立處方者，以了解計畫是否承保另一種藥物。
- ➢ 請求計畫授予「例外情況」以承保您的藥物，或是以較低費用分攤金額承保藥物。
- ➢ 如果您不同意計畫的裁決，您可以依照計畫駁回通知上的指示提出申訴。請留意提出申訴的時間限制。

Extra Help with Drug Plan Costs for People with Limited Incomes

The Social Security Administration (SSA) 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 program is called the Low-Income Subsidy Program (LIS), also known as Extra Help. People with Medicaid and/or a Medicare Savings Program (MSP) are automatically enrolled in Full Extra Help; one can also apply directly through SSA for Extra Help. One does not need to be collecting Social Security benefits to receive Extra Help.

Full Extra Help is for beneficiaries with monthly incomes up to 135% of the Federal Poverty Level, and resource limits within the amounts stated below. 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, as long as the plan selected is a "benchmark" plan, a Basic plan that has a monthly premium that is fully subsidized by Extra Help (monthly premium up to $36.55 in 2020).
- No deductible.
- Reduced co-pays, depending on income - beneficiaries with incomes up to 100% of the Federal Poverty Level will have co-pays of $1.30 for generic and $3.90 for brand name prescriptions. All others with full Extra Help will have co-pays limited to $3.60 for generic and $8.95 for brand name prescriptions.

Partial Extra Help is for beneficiaries with monthly incomes up to 150% of the Federal Poverty Level and resource limits within the amounts stated below. Resources 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 $89.
- Reduced co-pays – pay the lower of 15% of drug costs or the plan's cost-sharing.

Extra Help Income and Asset Limits (2020)

	Individual		**Married Couple**	
	Monthly Income	Assets	Monthly Income	Assets
Full Extra Help	$1,456	$9,360	$1,960	$14,800
Partial Extra Help	$1,615	$14,610	$2,175	$29,160

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.

對收入有限人士之藥品保險計畫費用的額外補貼

社會安全局 (SSA) 為低收入及資產有限的聯邦醫療保險受益人提供對 D 部分計畫費用的補貼。補貼金直接付予 D 部分計畫。該項計畫的名稱為低收入補貼計畫 (LIS)，亦即額外補助 (Extra Help)。已登記加入聯邦醫療保險及/或聯邦醫療保險免保費計畫 (MSP) 的人可自動登記加入全額額外補助；這類人士也能直接透過 SSA 申請額外補助。不必領取社會安全福利，即可領取額外補助。

全額額外補助適用於月收入在聯邦貧窮線之 135% 以下且資產限制落在以下金額的受益人。資產包括額外的個人 $1,500 及伴侶 $3,000 之喪葬開支。

全額額外補助的福利：

- D 部分計畫無每月額外費用，只要選定為基準型計畫，即可享有由全額額外協助的完整補貼（2020 年每月額外費用最高為 $36.55）。
- 無自付額。
- 減免的共付額依收入而定，若受益人收入在聯邦貧窮標線的 100% 以下，非原廠等同藥共付額將為 $1.30，原廠處方藥共付額則為 $3.90。其他領取全額額外補助者的共付額限定為非原廠等同藥 $3.60，而原廠處方藥為 $8.95。

部分額外補助適用於月收入在聯邦貧窮線之 150% 以下且資產限制落在以下金額的受益人。資產包括額外的個人 $1,500 及伴侶 $3,000 之喪葬開支。

部分額外補助之福利：

- 將根據其收入而繳交遞減的月保費。
- 自付額減為 $89 以下。
- 減免的共付額 - 支付藥物費用的 15% 或是計畫的分攤費用。

額外補助收入和資產限制 (2020)

	個人		已婚夫妻	
	月收入	資產	月收入	資產
全額額外補助	$1,456	$9,360	$1,960	$14,800
部分額外補助	$1,615	$14,610	$2,175	$29,160

HIICAP 輔導員能協助查核是否具有申請額外補助的資格，社會安全局也能提供協助。若要申請額外補助，或致電社會安全局 1-800-772-1213 （1-800-325-0778 聽障專線），或上網申請請至 www.socialsecurity.gov。您可以在今年的任何時間申請額外補助。

Individuals with Extra Help will not be subject to a late enrollment penalty in Part D. Additionally, those with Extra Help may change their Part D plan at additional times during the year. See page 34 for more information.

There are cases where someone is automatically eligible for Extra Help but is not enrolled in a Part D plan. The Limited Income Newly Eligible Transition (LINET) Program, administered by Humana, may be able to help. LINET can get you retroactive or temporary prescription drug coverage while you enroll in a Part D plan. You may need documentation of Best Available Evidence that you are eligible for Extra Help, such as a Medicaid award letter, a MSP award letter, or proof of SSI. LINET can be reached at 1-800-783-1307.

領取額外補助者將不會被處以 D 部分延遲登記罰金，領取額外補助的人可以在一年中的其他時間變更自己的 D 部分計畫。詳情請參見第 34 頁。

有時候某人會自動獲得額外補助，而未登記加入 D 部分計畫。由 Humana 管理的「限制性收入新條件轉變」 (LINET) 計畫可能會為此提供幫助。在登記加入 D 部分計畫時，LINET 可幫助您取得追溯性或臨時的處方藥保險。您可能需要您符合額外補助的「最佳證據」文件，例如醫療補助裁定通知書、MSP 裁定通知書或社會安全補助金 (SSI) 證明。LINET 的聯絡電話為 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 New York State's senior citizens. If you are 65 years old or over, 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 with 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 meeting any Part D deductible, EPIC is 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 the annual fee associated with their income, set on a sliding scale. Fees are based on the previous year's annual income and are paid quarterly. For example: a single person with an income of $16,000 would be responsible for an annual fee of $110. A couple with an income of $24,000 would pay $260 per person to participate in EPIC's Fee Plan. After paying the fee, participants pay the EPIC co-pay for their medications, based on their Part D plan's deductible and cost-sharing.

EPIC pays the Part D monthly premium for Fee Plan members, up to $36.55 per month in 2020. In addition, EPIC members with full Extra Help (see page 36) will have their EPIC fees waived.

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. To participate in the Deductible Plan, participants pay for their prescriptions until they meet their EPIC deductible amount, which is based on the previous year's income. After meeting the deductible, participants pay only the EPIC co-pay. For example, a single person with an income of $23,000 must meet an annual deductible of $580. For a married couple with an income of $29,000, each person must meet an annual deductible of $700. <u>There is no fee to join the deductible plan.</u>

紐約州老人藥品保險 (EPIC) 計畫
（老人藥品保險）

老人藥品保險計畫 (EPIC) 是紐約州針對老人實施的處方藥保險計畫。凡是年滿 65 歲以上，居住在紐約州，單身者收入在 $75,000 以下／已婚夫妻收入在 $100,000 以下，就有資格申請 EPIC。紐約州大多數的藥局都參與 EPIC 計畫。

您必須參加 D 部分保險 (PDP 或 MA-PD) 以擁有 EPIC，但是若您尚未參加 D 部分而登記加入 EPIC，您可以隨時選擇 D 部分計畫。擁有全額醫療補助的個人無資格參加 EPIC（參加醫療補助抵降保費計畫的個人仍有資格參加 EPIC）。

EPIC可作為聯邦醫療保險 D 部分的副保險，以降低藥物費用。在藥房按處方配藥時，EPIC 會員應該出示其 D 部分卡及其 EPIC 卡。在滿足任何 D 部分自付額之後，EPIC 是副保險。EPIC 也承保核准的 D 部分排除藥物，包括處方維生素和咳嗽與感冒藥。

EPIC 年費計畫和自付額計畫
EPIC 分為兩種計畫，即年費計畫和自付額計畫。申請人不能決定要參加那一種計畫；EPIC 會根據個人/夫妻的收入來決定。

EPIC 的年費計畫是針對個人年收入在 $20,000 以下和已婚夫婦年收入在 $26,000 以下者。欲參加年費計畫，參加者須視其收入繳交年費，以費率計算表設定。年費是根據前一年的年收入而定，按季繳納。例如：收入為 $16,000 的單身人士須繳交 $110 的年費。收入為 $24,000 的夫妻則須每人支付 $260 以參加 EPIC 的年費計畫。在支付費用之後，參與者會依據其 D 部分計畫自付額來支付其藥物的 EPIC 共付額。

EPIC 為年費計畫會員支付 D 部分月保費，2020 年每月最高至 $36.55。此外，取得全額額外補助（請見第 36 頁）的 EPIC 會員將免繳 EPIC 年費。

EPIC 的自付額計畫是針對年收入介於 $20,001 和 $75,000 的個人，以及年收入介於 $26,001 和 $100,000 的已婚夫婦。欲參加自付額計畫，參加者須自行支付他們的處方藥直至達到 EPIC 的自付額為止，該自付額是根據前一年的收入而定。在達到自付額之後，參加者只須支付 EPIC 共付額。例如，年收入為 $23,000 的單身人士必須達到 $580 的年度自付額。至於年收入為 $29,000 的已婚夫妻，每個人須達到的年度自付額為 $700。<u>參加自付額計畫無需繳費。</u>

EPIC pays the Part D monthly premium (up to $36.55 per month in 2020) 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 ($438.60 in 2020).

After a Deductible Plan member reaches his/her deductible, all that 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 cannot be applied to the EPIC deductible.

TIPS

- ✓ EPIC members without Extra Help may want to look into a Part D plan without a deductible; 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 Planfinder 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 26), so if someone cannot enroll in Part D for whatever reason, they are not eligible for EPIC.

<u>You can enroll in EPIC at any time of the year</u>. Even 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 enrollee pays the EPIC co-pay based on the amount remaining after the 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 also have EPIC, you would pay the EPIC co-pay on a $20 drug, which is $7. In addition, EPIC will cover you after you have met any Part D deductible, including during the initial coverage level, the coverage gap, and during catastrophic coverage, as long as 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 mail order pharmacies, even if that mail order pharmacy is outside of NY State. (EPIC will not pay the out-of-state pharmacy for a drug not covered by the Part D plan.)

EPIC is New York State's State Pharmaceutical Assistance Program (SPAP). SPAP members have a Special Enrollment Period (SEP), which allows you 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 additional time each year.

EPIC 為收入不高於 $23,000 的個人／$29,000 的已婚夫妻自付額計畫會員支付 D 部分月保費（2020 年每月最高至 $36.55）。收入更高的自付額計畫會員必須支付自身的 D 部分保費，但其 EPIC 自付額的降幅為基本 D 部分計畫的年度費用（2020 年約 $438.60）。

依據其共付額，自付額計畫會員達到其自付額後，他們只需要支付承保藥品的 EPIC 共付額即可。D 部分自付額階段產生的藥品費用不能應用於 EPIC 自付額。

提示

- ✓ 不享受額外補助的 EPIC 會員可能要看看無自付額的 D 部分計畫；EPIC 不保障 D 部分計畫自付額期間購買的處方藥。
- ✓ EPIC 登記和 EPIC 共付額並不會反映於 www.medicare.gov 計畫搜尋工具之中。

EPIC 如何與聯邦醫療保險 D 部分搭配運用？

紐約法律要求 EPIC 會員還須登記加入聯邦醫療保險 D 部分計畫（請見聯邦醫療保險 D 部分第 26 頁），若有人因故不能登記加入 D 部分，則其無資格參加 EPIC。

<u>您可以在一年中的任何時候登記加入 EPIC。</u>即使您在登記加入 EPIC 之時並無 D 部分計畫，您可在之後登記加入 D 部分計畫。

D 部分保險是主保險，EPIC 保險則永遠是副保險。參加者是根據 D 部分保險計畫支付後的餘額來支付 EPIC 共付額，因此可以降低參加者的負擔。例如，若您使用 D 部分保險計畫而應為藥品支付 $20 共付額，而您同時也有 EPIC，則藥品費用以 $20 作計算，最後您只需支付 $7 的 EPIC 共付額。此外，只要藥品獲得 D 部分計畫的初級承保，在您達到任何 D 部分自付額後，EPIC 將承保您的用藥（包括初級承保等級、承保缺口期間、以及重大傷病承保期間）。對於使用 EPIC 加盟郵購藥房的 D 部分計畫會員，即使郵購藥房不在紐約州，EPIC 亦將做為副保險賠付。（對於 D 部分計畫不承保的藥品，EPIC 將不會付款給位於他州的藥房。）

EPIC 是紐約州的州藥品協助計畫 (SPAP)。SPAP 會員擁有一個特殊參加期 (SEP)，該期間允許您每年可再一次登記加入或轉換 D 部分計畫（含 D 部分保險的一項聯邦醫療保險優勢計畫或 D 部分計畫搭配聯邦保險原始計畫）。

EPIC and Extra Help

EPIC requires members who appear to be income eligible for Extra Help to complete an additional form called Request for Additional Information (RFAI) 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 41) to help pay for the Medicare Part B premium.

Co-payments for Medicare Part D and EPIC covered or approved Part D excluded drugs:

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 actually 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

- You can 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 and to download and print an application. You can also submit an online request for EPIC to mail you an application.
- Fax the completed EPIC application to 518-452-3576, or mail the completed application to EPIC, P.O. Box 15018, Albany, NY 12212-5018.

EPIC 與額外補助

EPIC 會員的收入若符合資格申請額外補助，則必須填寫另一份名為「索取更多資料」(RFAI) 的表格，如此 EPIC 即可代為向社會安全局申請額外補助。額外補助申請表也將轉介至紐約州醫療補助計畫，以評估是否符合聯邦醫療保險免保費計畫（請見第 41 頁）的資格，而可獲得支付 Medicare B 部分保費的協助。

聯邦醫療保險 D 部分和 EPIC 承保或核准的 D 部分不承保藥品的共付額：

處方藥費用（在提交 聯邦醫療保險 D 部分計畫之後）	EPIC 共付額
最多 $15	$ 3
$15.01 至 $35	$ 7
$35.01 至 $55	$ 15
$55 以上	$ 20

EPIC 與雇主／退休藥品保險

EPIC 必備條件為加入 D 部分計畫；擁有雇主／退休藥品保險的人士將不能擁有 EPIC，因為加入 D 部分計畫極可能影響其雇主／退休藥品保險。然而，有時雇主／退休藥品保險實際上被視為是 D 部分計畫，在這種情況下，個人還可以擁有 EPIC。**請洽詢相關福利管理部門以瞭解藥品保障。**

申請 EPIC

- 您可致電 1-800-332-3742（聽障專線：1-800-290-9138）向 EPIC 索取申請表。
- 請造訪 https://www.health.ny.gov/health_care/epic/ 以取得更多 EPIC 相關資訊，下載並列印申請表。也可以上網索取，請 EPIC 郵寄一份申請表給您。
- 將填妥的申請表傳真至 518-452-3576，或將填妥的申請表郵寄至 EPIC, P.O. Box 15018, Albany, NY 12212-5018。

MEDICARE SAVINGS PROGRAMS

Medicare Savings Programs (MSP) can help eligible individuals pay for their Medicare premiums and other costs associated with Medicare. MSPs are administered by the Human Resources Administration (HRA) in New York City. One 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 is information on the Medicare Savings Programs, followed by income limits for each of the programs, 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 the coinsurance and deductibles for Parts A and B. An individual can be eligible for QMB only, or for QMB as well as Medicaid. Individuals with QMB should see providers who accept both Medicare and Medicaid if they want full Medical coverage with no out-of-pocket costs.
  - NEW: QMB status is now noted on the Medicare Summary Notice, making it clear that the QMB beneficiary is not responsible for any Medicare cost-sharing.
  - SSI recipients should be auto-enrolled in QMB when they become Medicare eligible and should be enrolled 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 be eligible for 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 be eligible for both QI and Medicaid. The applicant must have Medicare Part A to be eligible for QI.

MSP Monthly Income and Resource Limits - 2019				
	Single		**Married Couple**	
	Income	Resources	Income	Resources
QMB: 100% FPL	$1,061	No Limit	$1,420	No Limit
SLMB:120% FPL	$1,269	No Limit	$1,711	No Limit
QI: 135% FPL	$1,426	No Limit	$1,923	No Limit

MSP Monthly Income and Resource Limits – 2020 estimate				
	Single		**Married Couple**	
	Income	Resources	Income	Resources
QMB: 100% FPL	$1,083	No Limit	$1,457	No Limit
SLMB:120% FPL	$1,296	No Limit	$1,744	No Limit
QI: 135% FPL	$1,456	No Limit	$1,960	No Limit

聯邦醫療保險免保費計畫

聯邦醫療保險免保費計畫 (MSP) 能幫助符合資格的個人支付其聯邦醫療保險保費及其他與聯邦醫療保險相關的費用。聯邦醫療保險免保費計畫是由位於紐約市的人力資源管理局 (HRA) 管理。您可以在一年中的任何時候申請加入 MSP。MSP 的授權為期 12 個月；HRA 每年會郵寄續期資料包以評估後續合格條件。

以下為聯邦醫療保險免保費計畫的資訊，之後則是每項計畫的收入限制及如何適用。

- **合格聯邦醫療保險受益人計畫 (QMB)**：本計畫可支付 Medicare A 部分和/或 B 部分保費，以及 A 部分和 B 部分的共保額和自付額。個人可能只符合 QMB 的資格，也可能同時符合 QMB 和醫療補助的資格。擁有 QMB 者若想享有全額醫療賠付而無須負擔自付費用，就應該去前往同時接受聯邦醫療保險和醫療補助的醫療業者處就診。
  - 新項：QMB 狀態現在出現於聯邦醫療保險概要通知之中，明確顯示 QMB 受益人並不負責任何聯邦醫療保險費用分攤。
  - 當 SSI 領取者符合聯邦醫療保險資格、而且應該登記加入聯邦醫療保險 A 部分和 B 部分時，他們應該被自動加入 QMB。
- **特定低收入聯邦醫療保險受益人計畫 (SLMB)**：本計畫支付聯邦醫療保險 B 部分保費。個人可能只符合 SLMB 的資格，也可能同時符合 SLMB 和醫療補助（抵降保費計畫）的資格。申請人必須擁有聯邦醫療保險 A 部分才能有資格申請 SLMB。
- **合格個人計畫 (QI)**：本計畫支付聯邦醫療保險 B 部分保費。個人不能同時符合 QI 和醫療補助的資格。申請人必須擁有聯邦醫療保險 A 部分才能有資格申請 QI。

MSP 月收入及資產上限 - 2019				
	單身		已婚夫妻	
	收入	資源	收入	資源
QMB：100% FPL	$1,061	不限	$1,420	不限
SLMB：120% 聯邦貧窮	$1,269	不限	$1,711	不限
QI：135% FPL	$1,426	不限	$1,923	不限

MSP 月收入及資產上限 - 2020 年預估值				
	單身		已婚夫妻	
	收入	資源	收入	資源
QMB：100% FPL	$1,083	不限	$1,457	不限
SLMB：120% 聯邦貧窮	$1,296	不限	$1,744	不限
QI：135% FPL	$1,456	不限	$1,960	不限

Applying for a Medicare Savings Program

- One can apply through a Deputized Agent, at the local Medicaid office, or by mail.
  - 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 212-244-6469 and ask for HIICAP. You can also reach out to the Medicare Rights Center at 1-800-333-4114.
  - Reach out to a Facilitated Enroller. Visit https://www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf or call 347-396-4705 to locate a center near your home where you can get assistance completing the application.
  - 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.

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 form, the DOH-4328, 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, DOH-4220 application 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 on a monthly basis, 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 which can reduce the amount of money that is counted when determining MSP eligibility. This can include health insurance premiums that are paid, for example: Medigap premiums, Long Term Care Insurance premiums, retiree health insurance premiums, and dental insurance.
  Note: The MSP program requires that you be collecting any Social Security benefits for which you are eligible, unless delaying Social Security because you are working full time.

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 36).
- If you apply for Extra Help through the Social Security Administration, SSA will forward your information to New York State to be considered for MSP eligibility.
- You may qualify for a Medicare Savings Program even if still working due to earned income disregards.

申請聯邦醫療保險免保費計畫

- 申請人可透過暫委代表，在當地醫療補助辦事處，或透過郵件申請。
  - 暫委代表將協助您填妥申請表並收集所需的必要文件。欲約見 HIICAP 暫委顧問，請致電 Aging Connect 專線 212-244-6469 並洽詢 HIICAP。您亦可致電 1-800-333-4114 洽詢聯邦醫療保險權益中心。
  - 請聯絡參保促進者。造訪 https://www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf 或致電 347-396-4705 以找到您家附近的中心，在那裡您可以得到協助完成該申請。
  - 請將填妥的申請表及所需文件的副本一併寄至：Medical Assistance Program; MSP-CREP, 5th Floor; P.O.Box 24330; Brooklyn, NY 11202-9801。

使用哪種申請表？

- 若您只申請聯邦醫療保險免保費計畫（而非醫療補助及一項聯邦醫療保險免保費計畫），您可使用簡化的聯邦醫療保險免保費申請表，DOH-4328，網址為 https://www.health.ny.gov/forms/doh-4328.pdf。
- 若您同時申請聯邦醫療保險免保費計畫及醫療補助，您必須使用聯邦醫療保險免保費申請表及 Access NY Health Care，DOH-4220 申請表可在下列網址取得：https://www.health.ny.gov/forms/doh-4220.pdf。

申請 **MSP** 時，會將哪些項目計入收入？

- 收入包含來自雇主或自雇者的薪資。這也包含每月領取的資金，例如社會安全福利、年金、退伍軍人福利、失業保險等，以及透過 IRA、401K、403B 或其他退休帳戶固定分發的福利。
- 某些收入將不被計入，當決定聯邦醫療保險免保費計畫 (MSP) 資格時，被計入的金額會被減少。這可以包含已支付的健康保險保費，例如：聯邦醫療保險補充保險保費、長期護理保險保費、退休人士健康保險保費，以及牙科保險。
  註：除非您因為從事全職工作而延遲申領社會安全福利金，在申請MSP時，您必須申領所有符合資格的社會福利金。

聯邦醫療保險免保費計畫宣導提示：

- 加入 MSP 的個人自動符合領取全額額外補助的資格，以降低聯邦醫療保險 D 部分藥品費用（請見第 36 頁）。
- 如果您透過社會安全局 (SSA) 申請額外補助，SSA 將向紐約州轉送您的資訊，以考察是否符合聯邦醫療保險免保費計畫的資格條件。
- 即使您仍在工作，因為勞動所得不被計入，您仍可能符合聯邦醫療保險免保費計畫的資格。

MEDICARE FRAUD AND ABUSE

The federal government estimates that billions of dollars--approximately ten percent 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 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 which may not be fraudulent, but which 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 to Medicare beneficiaries but not to 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 and door-to-door selling as a way 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 for home health care providers that offer non-medical transportation services 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 other coverage to the actual care.

聯邦醫療保險的詐騙與濫用

聯邦政府估計，因詐騙、浪費和濫用所造成的損失達數十億美元，約是聯邦醫療保險支出的 10%。因此鼓勵受益人對於任何可疑的收費保持警覺性並及時通報。

什麼是<u>詐騙</u>？
詐騙是指以欺詐的手段取得或企圖取得服務或款項，這些手段是故意的、出於自願的，並且完全清楚自己的行為。詐騙的例子包括：
- 回扣、賄賂或退款。
- 使用他人的聯邦醫療保險卡或號碼取得服務。
- 計費的項目或服務並未真正提供。
- 同樣的服務在相同日期或不同日期計費兩次。
- 計費的服務不在承保範圍內，例如：牙科護理、例行足部護理、聽力服務、例行眼科檢查等等，但卻假裝是承保的服務。
- 同時向兩方收取費用，例如：同時向聯邦醫療保險和另一家保險業者收費，或同時向聯邦醫療保險和病患收費，企圖重複收費。

什麼是<u>濫用</u>？
濫用的事件和作為可能並非詐騙，但可能導致聯邦醫療保險計畫的損失。濫用的例子包括：
- 過度使用醫療及健康護理服務。
- 不當的收費行為。
- 提高對聯邦醫療保險受益人的收費，但對其他病患的收費不變。
- 發現錯誤時並未更正帳戶的收費。
- 常規性地免除聯邦醫療保險 B 部分自付額以及 20% 的共同保險。

<u>聯邦醫療保險注意事項</u>
- 絕對不可以將自己的聯邦醫療保險號碼交給不認識的人。如果您認為某人盜用您的聯邦醫療保險受益人標識碼 (MBI)，請向聯邦醫療保險回報此事。
- 特別注意私營健康保險計畫、醫生及相關業者利用電話行銷或上門推銷的方式向您銷售商品及服務。
- 持懷疑態度對待自稱是代表聯邦醫療保險的人士。聯邦醫療保險不會打電話給受益人，也不會登門造訪。
- 保持警覺性來面對提供免費禮物以換取聯邦醫療保險號碼的業者。
- 密切注意居家護理業者提供非醫療性交通服務或家事服務，而列為聯邦醫療保險核准的服務。
- 持懷疑態度對待宣稱有辦法讓聯邦醫療保險支付未承保服務的人士。
- 保存記錄，記載就醫看診的詳情，並在處理帳單時比對聯邦醫療保險摘要通知 (MSN) 和其他保險項目是否與實際接受的醫療護理相符。

Be alert to:

- Duplicate payments for the same service.
- Services that you do not recall receiving.
- Services billed 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. Detail 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 Medicare beneficiaries assist the Medicare program in finding 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 Fraud & Abuse with Medicare Part D plans,
Call Medic at 1-877-7SafeRx.

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/section/scams-and-identity-theft.

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 the legitimacy of their need for this information. Be an informed and proactive consumer.

以下狀況須提高警覺：

- 對同一項服務重複收費。
- 不記得曾接受過該項服務。
- 欲收費的服務與您所接受的服務不同。
- 您已付費予業者而聯邦醫療保險又為該項服務付款。

如何通報聯邦醫療保險的詐騙行為

若您確信有醫療保險的詐騙或濫用情事，請致電1-800-333-4374。請盡量詳述下列資訊：

- 醫療業者或公司名稱，以及其姓名旁邊的任何識別號碼。
- 您的姓名、地址和電話號碼。
- 服務日期。
- 所申報的服務類別或項目
- 聯邦醫療保險所核准並賠付的金額。
- 聯邦醫療保險摘要通知 (MSN) 的日期。
- 簡要說明敘述問題。盡可能針對重點明確說明。

聯邦醫療保險受益人協助聯邦醫療保險計畫找出詐騙或濫用行為，不但是為聯邦醫療保險省錢一也是為您自己一省錢。

欲通報聯邦醫療保險的詐騙和濫用，
請致電 **SMP**（老人醫療保險巡邏計畫），電話為：**1-800-333-4374**。

欲通報聯邦醫療保險 **D** 部分計畫的詐騙及濫用，
致電 **Medic** 請撥打 **1-877-7SafeRx**。

詐騙和濫用是大家的問題，大家都能提供協助！

身份盜用

聯邦貿易委員會提供關於如何保護身份資料的資訊。請洽詢聯邦貿易委員會，或致電 1-877-438-4338 或至 www.consumer.gov/section/scams-and-identity-theft 提出投訴。

請保護您的聯邦醫療保險號碼和社會安全號碼，以及您的出生日期和任何其他個人資料，例如：銀行或信用卡資料。對於向您索取這些資料者，須小心謹慎並提出疑問，並且詢問他們需要這些資料的合法性，不要遲疑。做一位掌握資訊且積極主動的消費者。

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 in order to be eligible. Once an individual is determined to be Medicaid eligible, a permanent plastic Medicaid card is issued and is valid as long as he or she remains eligible. In addition to financial guidelines, Medicaid requires that you be a U.S. citizen or qualified alien. In order to apply for Medicaid in NYC you must reside in NYC.

MEDICAID COVERED SERVICES

- 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; those under 65 and not blind or disabled apply through the NY State of Health. This section discusses how individuals 65+, blind or disabled apply for Medicaid. See page 52 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** refers to Medicaid that people use when they are living in their home and using Medicaid for health insurance coverage.
- **Institutional Medicaid** refers to Medicaid providing the full range of health coverage AND paying for care in a nursing home on a full-time basis (this is different from care in a skilled nursing facility, which is temporary and covered by Medicare Part A).

COMMUNITY MEDICAID has a **maximum monthly countable income** of $875 for single individuals/$1,284 for married couples, and an **asset** limit of $15,750 (plus $1,500 in a burial fund) for single individuals/ $23,100 (plus $3,000 in burial funds) for married couples in 2020.

針對 65 歲以上老人、盲人或殘障人的醫療補助資格
非 MAGI 聯邦醫療保險

醫療補助是聯邦、州及市政府共同為低收入人士而開辦的健康保險計畫。醫療補助是須「經過經濟情況調查」的計畫，申請人必須證明財務需要才能符合資格。一旦個人被確定符合醫療補助資格，將發予一張永久性的塑膠製醫療補助卡，只要當事人仍符合資格就一直有效。除了財務準則以外，必須是美國公民或符合資格的外籍人士才能申請醫療補助。您必須居住在紐約市，才能在紐約市申請醫療補助。

醫療補助承保的服務

- 急診及住院服務
- 預防性保健服務
- 個人護理服務
- 個案管理服務
- 核准的處方藥
- 物理治療
- 言語和聽力復健
- 結核病 (TB) 相關服務
- 心理健康服務
- 私人看護
- 助聽器
- 診斷服務
- 職能服務
- 門診服務
- 篩檢服務
- 復健服務
- 安寧療護
- 眼鏡及驗光服務
- 牙科服務和假牙
- 義肢輔具
- 交通
- 家庭醫療護理

您可以在哪裡及如何申請醫療補助視您的「類別」而定：65 歲以上老人、盲人或殘障人可透過紐約市人力資源管理局申請；未滿 65 歲及非盲人或非殘障人則可透過紐約州衛生署申請。本節討論身為 65 歲以上、眼盲或殘障的人士如何申請醫療補助。請參照第 52 頁，了解未滿 65 歲且未有失明或失聰人士的醫療補助相關資訊。

65 歲以上、眼盲或殘障的人士可能在不同的方面符合醫療補助資格，這視他們正在申請的服務而定。

- **社區醫療補助**指的是人們使用的醫療補助，其時他們居住在自己家裡並且將醫療補助作為健康醫療保險。
- **機構醫療補助**指的是醫療補助，提供全系列健康醫療保險**並且**支付專職護理院全部時間護理 (這與臨時性、而且為聯邦醫療保險 A 部分所承保的專業護理設施的護理不同)。

社區醫療補助 2020 年規定：**月度可計收入上限** (單身人士為 $875/已婚夫妻為 $1,284）以及**資產**限制 (單身人士為 $15,750，外加在喪葬基金中的 $1,500)/已婚夫妻為 $23,100，外加在喪葬基金中的 $3,000)。

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 spend down your "excess amount," the amount by which you are over Medicaid's income limit, on health expenses and then you have full Medicaid coverage for the remainder of the month.

Assets include cash, bank accounts, IRAs 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.

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 41).

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, in both English and Spanish, at www.health.ny.gov/health_care/medicaid/#trusts.

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. HIICAP counselors can direct you to an agency in your borough or you can visit 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. See page 63 for a list of Medicaid offices, 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/Medicaid Assistance Program
  P.O. Box 2798
  New York, NY 10117-2273

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.

醫療補助計算來自所有來源的**收入**，包括工資以及社會安全金和年金付款。另有某些可允許的**收入扣除額**，因此即使收入超過上述金額，仍歡迎申請。另外，如果您的收入超過這些金額，您就可能有資格參加醫療補助的**超額收益計畫（也稱為醫療補助抵降保費計畫）**。參加保費抵降計畫，您抵降您健康費用的「超過金額」，您超過醫療補助收入限制的金額，然後您擁有當月剩餘部分的醫療補助全額保險。

資產包括：現金、銀行帳戶、個人退休帳戶 (IRA) 和股票。某些資產不在限制之內，包括：主要住宅、汽車和私人物品。社區醫療補助申請人必須證明申請之月的資產；沒有社區醫療補助資產轉移的回溯期。

對於醫療補助如何計入收入和資產的完整清單，請造訪醫療補助參考指南：www.health.ny.gov/health_care/medicaid/reference/mrg/。若是收入和/或資產超過醫療補助所容許的金額，您可能需要考慮申請聯邦醫療保險免保費計畫，以協助支付聯邦醫療保險的保費和其他與聯邦醫療保險相關的費用（請參閱第 41 頁）。

醫療補助申請：申請者填寫獲得紐約醫療護理 (Access NY Health Care) 申請，表格 DOH 4220 以及補充 A。您可以獲得英文版和西班牙語版的申請和說明：www.health.ny.gov/health_care/medicaid/#trusts。

申請表應遞送至何處？
您可以選擇遞送醫療補助申請表的地點和方式：
- 請聯絡您附近的一位加入促進者尋求協助。HIICAP 輔導員能夠將您指引至您所在行政區的一家機構，您也可以造訪 www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf 以取得完整的加入者清單。
- 至當地的醫療補助辦事處 – 您可在辦事處取得協助以親自填妥申請表，或投遞已填妥的申請表。請見第 63 頁的醫療補助辦事處一覽表並致電人力資源管理局 311，或造訪網站：www1.nyc.gov/site/hra/locations/medicaid-locations.page。
- 郵寄申請表。請將填妥的申請表及所需文件一併寄至：

  Initial Eligibility Unit
  HRA/Medicaid Assistance Program
  P.O.Box 2798
  New York, NY 10117-2273

重新認證：醫療補助獲得為期 12 個月的授權。在大約第 9 個月的保障中，HRA 會郵寄一個必須填寫完整的重新認證包，以便判定續保資格。

<u>Eliminating the "Spenddown" for Medicaid Applicants</u>

<u>Disabled</u> individuals of any age with community Medicaid services including home care, adult day care and prescription drug costs can utilize all of 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 "surplus" or "spenddown" moneys to Medicaid. The pooled-income trust fund, managed by a nonprofit agency, receives the individual's monthly surplus income and redistributes it on behalf of that individual as directed by the individual or their legal representative. Please speak to an eldercare lawyer or a knowledgeable geriatric care manager for further information regarding estate planning and the supplemental needs trust.

For more information, contact the Evelyn Frank Legal Resources Program at 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 eligibles." Medicare is primary coverage and Medicaid secondary. In addition to paying for Medicare's cost-sharing requirements, such as the Part A deductible and Part B deductible and 20% co-insurance, Medicaid in New York also offers benefits, such as home health care, and dental and vision services, which are not covered under the Medicare program.

Like all Medicare beneficiaries, dual eligibles can choose how they receive their Medicare and Medicaid benefits. It is important to confirm coverage with any providers. Here are the different ways that dual eligibles 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 specifically designed for dual eligibles - these are HMOs that provide all Medicare A + B + D benefits, as well as the full range of Medicaid covered services.
- Medicare Advantage Plan with Part D + fee-for-service Medicaid (NYS Benefits Card).

How does Medicaid interact with Medicare Part D?

Dual eligibles are automatically enrolled in full Extra Help (see page 36) and will be automatically enrolled in a Part D plan if they do not sign up for one on their own. As long as a dual eligible is enrolled in a Part D plan that is classified as a "benchmark" plan, he/she will pay no premium for Part D coverage. Dual eligibles with incomes under 100% of the Federal Poverty Level (FPL) will have co-pays of $1.30 for generic/$3.90 for brand name prescriptions in 2020. Those with incomes over 100% FPL will have co-pays of $3.60 for generic/$8.95 for brand name prescriptions.

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

<u>消除針對醫療補助申請人的「抵降」</u>

<u>殘障</u>人士不論年齡，只要是接受社區型醫療補助服務，包括：居家護理、成人日間照護和處方藥費用，經由參加**補助需求信託**，就可以把他們的全部收入用於支付生活支出。設定補助需求信託消除了當事人需要建構其醫療補助的「盈餘」或「抵降」金錢之需求。此一集合式收入信託基金是由非營利機構管理，在收到個人的每月收入盈餘之後，會根據其本人或法律代表的指示為其進行重分配。請洽詢專精老年護理規劃的律師或學識豐富的老人護理管理人員，以進一步瞭解關於資產規劃和補助需求信託的資訊。

如需詳細資訊，請聯絡 Evelyn Frank 法律資源計畫紐約法律援助組：212-613-7310，或寄送電子郵件至 EFLRP@NYLAG.org。

醫療補助與聯邦醫療保險如何發揮作用？

有可能同時取得醫療保險和醫療補助。同時參加醫療保險和醫療補助的人被稱為「雙重資格者」。聯邦醫療保險是主保險，而醫療補助是副保險。除了支付醫療補助的費用分攤要求之外，例如 A 部分自付額和 B 部分自付額及 20% 共保額，紐約州的醫療補助還提供不在聯邦醫療保險計畫範圍的福利，例如家庭醫療護理以及牙科和視力服務。

就像所有聯邦醫療保險受益人一樣，雙重資格者可以選擇他們如何收到其醫療保險和醫療補助福利金。重要的是要與任何保險業者確認保障。以下是雙重資格者可以獲得其醫療保險和醫療補助福利的不同方式：

- 聯邦醫療保險原始計畫（紅卡、白卡和藍卡）+ 付服務費的醫療補助 （紐約州福利卡）+ 醫療保險 D 部分計畫。
- 專門為雙重資格者設計的特殊需求計畫 - 這些是提供所有醫療保險 A + B + D 福利的 HMO 以及全系列醫療補助承保的服務。
- 醫療保險優勢計畫（參加 D 部分）+ 付服務費的醫療補助 （紐約州福利卡）。

醫療補助與聯邦醫療保險 D 部分如何交互運作？

雙重資格者自動加入全額額外補助（請參閱第 36 頁），而且若他們沒有主動報名參加一項計畫，將自動參加 D 部分計畫。只要雙重資格者登記參加被分類為「基準」計畫的 D 部分計畫，其將不支付 D 部分保險的保費。2020 年，具雙重資格者的收入若在聯邦貧窮線 (FPL) 的 100% 之下，所負擔的共付額為非原廠等同藥 $1.30/原廠品牌藥 $3.90。收入超過 100% 聯邦貧窮線者的共付額為非原廠等同藥 $3.60/原廠品牌藥 $8.95。

根據法律規定，某些藥品並不在 D 部分的保障內，例如非處方藥物和維他命。如有處方，這些藥品將繼續由醫療補助承保。

Mandatory Medicaid Managed Long Term Care:

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

Dual eligibles in need of Medicaid-covered personal care, home care, 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:

1. Call New York Medicaid Choice at 855-222-8350 to request a CFEEC appointment. CFEEC, the Conflict Free Evaluation and Enrollment Center, evaluates the need for home care services for people newly in need of long term care services. CFEEC only determines WHETHER one needs home care. CFEEC does NOT determine the type of home care or the number of hours of care. If CFEEC determines that the client needs long term care services, defined as 120+ days of home care within a year, the client must enroll in a managed long-term care plan for at least their home care services.

2. 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 from New York Medicaid Choice, telling you about your choices and how to enroll. You will have 60 days to enroll in a plan. 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).

   Since it is the managed long-term care plans that determine the type of care and the number of hours of care that they would provide, the client may want to meet with more than one plan to compare the type of care, and how many hours of care, the different plans would approve.

   There are **three types** of managed long-term care plans from which to choose:
   - **Managed Long Term Care (MLTC):** MLTC plans provide long term care services, as well as a few other services, such as home modifications, non-emergency medical transportation, podiatry, audiology, dental and optometry. This is the most flexible of the managed long-term care plan options, as you can maintain you current Medicare and Medicaid provider arrangements. MLTC enrollees will continue to use their current plan (i.e. your Medicare card, your Medicaid card, or your Medicare Advantage card) for all other Medicare and Medicaid services. Individuals who do not enroll in a managed long-term care plan on their own will be automatically enrolled into an MLTC plan.
   - **Medicaid Advantage Plus (MAPlus):** MAPlus plans provide ALL Medicaid AND Medicare services, including long-term care services, from the same plan and must use in-network providers.
   - **Programs of All-Inclusive Care for the Elderly (PACE):** PACE plans provide all Medicaid and Medicare services, including long-term care services. Members receive services from the same plan and must use in-network providers. The PACE plans differ from MAPlus plans in that enrollees 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.

強制性醫療補助管理的長期護理：

申請個人護理服務、家庭護理服務或私人看護的醫療補助

需要醫療補助承保的個人案例、家庭護理、或私人看護的具雙重資格者必須首先申請醫療補助並收到醫療補助核准（有或無抵降），然後再遵循以下步驟：

1. 致電紐約醫療補助選擇熱線 855-222-8350 以申請 CFEEC 預約。CFEEC，即無衝突評價和登記中心，評價新近需要長期護理服務之人員的家庭護理服務需要。CFEEC 僅判定一個人是否需要家庭護理。CFEEC 不判定家庭護理的類型或護理的時數。若 CFEEC 判定客戶需要長期護理服務，定義為一年内 120 天以上的家庭護理，該客戶必須登記加入一項管理式長期護理計畫，至少使用其家庭護理服務。

2. 如果您獲準參加聯邦醫療保險的長期護理，您需要登記加入聯邦醫療補助管理式長期護理計畫（Medicaid Managed Long Term Care）。您將收到一個寄自紐約醫療補助選擇的包裹，告訴您關於您的選擇及如何登記加入。您將有 60 天的時間加入一項計畫。若您不自行選擇一項計畫，您將自動加入一項管理式長期護理計畫（請參閱下面的第一個要點）。

   既然是管理式長期護理計畫確定他們將會提供護理的類型和時數，該客戶可能會需要與不止一項計畫會面，以對比不同計畫將會核准之護理的類型及護理時數。

   有**三種類型**的管理式長期護理計畫供從中選擇：
   - **管理式長期護理 (MLTC)**：MLTC 計畫提供長期護理服務以及少數其他服務，例如居家護理改善、非緊急性醫療交通、足部醫療、聽覺病矯治、牙科護理及驗光服務。這是最靈活的管理式長期護理計畫選項，因爲您可以維持您當前的醫療保險和醫療補助業者安排。MLTC 加入者將繼續使用其當前的計畫（即您的聯邦醫療保險卡、醫療補助卡或聯邦醫療保險優勢計畫卡），獲取所有其他的聯邦醫療保險及醫療補助服務。不自行加入管理式長期護理計畫者，將自動被加入 MLTC 計畫。
   - **醫療補助加優 (MAPlus)**：MAPlus 計畫提供**所有的**醫療補助**及**聯邦醫療保險服務，包括長期護理服務，可從同一計畫獲取服務，且會員必須使用網內的醫療業者。
   - **老人全方位護理計畫 (PACE)**：PACE 計畫提供所有的醫療補助及聯邦醫療保險服務，包括長期護理服務。會員可從同一計畫獲取服務，且會員必須使用網內的醫療業者。PACE 計畫與 MAPlus 計畫的不同之處在於，加入者必須至少達到 55 歲方能加入 PACE 計畫，且 PACE 計畫透過特定據點（例如醫療門診或醫院）提供服務。

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. In addition to submitting the DOH-4220 application, Supplement A and supporting documentation, they must also submit an M11-Q form, signed by a doctor, stating their specific health care needs, as well as an attestation of immediate need for such care. If approved for immediate-need home care, the applicant will receive services paid directly by the NYC Medicaid program, and need not go through the CFEEC or enrollment in a managed care plan. However, after receiving these services for a few months, the individual will be required to switch to managed care to continue receiving them. 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?

1. Decide what type of plan would best suit your needs (MLTC, MAPlus, or PACE).
2. 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 Planfinder at www.medicare.gov has the prescription drug information for these plans.
3. To enroll in the plan, call NY Medicaid Choice at 1-888-401-6582.

How will the plan determine how many hours of home care I will receive?
If you are in the process of selecting a plan, you can ask the plan to do an assessment so that you can have a written plan for the number of hours of home care you will receive if you enroll in that plan.

What if I want to switch managed long term care plans?
You can switch plans at any time, however this rule is expected to change. The new rule would bar people from changing plans for 9-months after the first 90-days in the plan. New York Medicaid Choice (Maximus) handles enrollment for Medicaid managed long-term care and can be reached at 1-888-401-6582.

若要進一步瞭解管理式長期護理計畫類型，請造訪：

- MLTC、MAP+ 和 PACE： https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_guide_e.pdf
- 計畫目錄： https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

對於**急需家庭護理服務**的醫療補助申請者，有一個適當程序，可在 7 天之內取得醫療補助核准以及在 12 天之內取得家庭護理核准。除了提交 DOH-4220 申請、補充 A 和支援文件之外，他們還必須提交一份 M11-Q 表，經醫生簽署，陳述其具體健康護理要求以及急需此類護理的證明書。若急需家庭護理獲準，申請者將會收到由紐約醫療補助計畫支付的服務，而不需要完成CFEEC或登記加入管理式護理計畫。但是，在收到這些服務數月之後，這個人將會需要轉換到管理式護理，才能繼續接受那些服務。以下是 HRA 醫療補助警示的連結，說明這個程序：www.wnylc.com/health/afile/203/614/。

管理式長期護理將會如何與醫療補助抵降協作？
許多人士藉助醫療補助抵降保費計畫，支付醫療補助承保的居家護理服務。該等人士會在健康保險計畫中支付醫療補助抵降保費計畫。若會員不支付抵降保費計畫，該計畫可將該會員除名。

如何選擇計畫？

1. 決定最符合您需求的計畫類型（MLTC、MAPlus 或 PACE）。
2. 諮詢您的醫療業者（家庭護理機構、醫療業者等）他們所加入的計畫，以挑選一個能繼續使用您醫療業者的計畫。若您希望加入 MAPlus 或 PACE 計畫，亦需透過該計畫獲取 D 部分處方藥保險；計畫搜尋器 (www.medicare.gov) 應有該等計畫的處方藥資訊。
3. 欲加入該計畫，請致電 1-888-401-6582 洽詢紐約醫療補助選擇 (NY Medicaid Choice)。

該計畫如何決定我將獲得的居家護理時數？
若您正在選擇計畫，您可要求作一次計畫評估，得出有關若您加入該計畫將獲得居家護理之時數的書面計畫。

若想轉換管理式長期護理計畫怎麼辦？
您隨時可以更換計畫，此規則預期會變更。新規定將會禁止人們在首次加入計畫 90 天內變更計畫，為期 9 個月。紐約醫療補助選擇 (Maximus) 處理登記加入醫療補助管理的長期護理事宜，可致電 1-888-401-6582 聯絡。

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, for nursing home residents, most of one's income will go toward the cost of the nursing home, except for a small monthly "personal care" allowance, unless they are expected to return home. Rules are more flexible if there is a spouse still living in the home.

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

Medicaid will impose a "transfer penalty" if any such transfers are found within the 5-year look-back period. The transfer penalty means that Medicaid will not pay for the nursing home stay for a period of time proportional to the amount of money transferred. In NYC in 2019, the total amount of money transferred will be divided by $12,419 to determine the number of months of the penalty period. For example, if an applicant was found to have transferred $124,190 to family members in the 5 years before the month of application, the penalty period would be 10 months long. That individual would have to find a way to private-pay for the nursing home stay for 10 months before Medicaid coverage would begin. There are certain exceptions to the transfer penalty; applicants should consult a lawyer for advice on these matters.

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. In 2020 under Medicaid, the community spouse may retain a minimum of $74,820 and a maximum of $128,640 in assets and $3,216 per month in income. However, when both spouses are in a home care situation, the Community Spouse Protection does not apply.

By law, states are required to impose estate recovery, which is a claim against the estate of the deceased person, including their home, for what Medicaid paid for the person's at-home or nursing home care. The claim process cannot begin until after the death of the surviving spouse or surviving minor child.

如何獲得管理式長期護理計畫的幫助？
獨立消費者維權網路 (ICAN) 是紐約州調解員計畫，服務對象是透過醫療補助管理式護理（包括 MLTC、MAPlus、老年人全方位護理計畫 (PACE) 以及主流醫療補助（帶有長期護理服務））接受長期護理服務的人士。ICAN 的聯絡電話為 1-844-614-8800。

機構護理醫療補助：收入和資產指南嚴格對待機構醫療補助。一般而言，對於搬入護理之家的患者，其收入的大部分將會歸入護理之家的支出，每月的小額「個人護理」津貼除外，除非他們預計返家。規則更具靈活性，若他們有配偶仍然居住在家中。

護理設施應該幫助準備和提交機構醫療補助 (Institutional Medicaid) 申請。除了一般的社區醫療補助 (Community Medicaid) 申請，申請人務必提供過去 5 年的資產文件。這 5 年「回溯期」允許醫療補助計畫識別為獲得醫療補助資格進行的非補償式轉讓。

若在這個 5 年回溯期之內發現任何此類轉帳，醫療補助將會施加「轉帳罰金」。轉帳罰金代表醫療補助將不支付護理院入住所轉帳金額成比例的時段。2019 年紐約市的轉帳總金額將會被除以 $12,419，以判定罰金期的月數。例如，若申請人被發現在申請當月的前 5 年之內曾將儲蓄帳戶中的 $124,190 轉帳給家庭成員，這個懲罰期將會延長至 10 個月。該個人將不得不想辦法私人支付在醫療補助保險本將開始之前在護理院入住的 10 個月。轉帳罰金有某些例外情況；申請者應該諮詢律師，尋求這些事宜的有關建議。

留在家中生活之配偶保障：當夫妻一方進入長期護理設施後，留在家中的配偶因須支付護理費用而受到財務保障。聯邦和紐約州法律規定，共同生活之配偶准予保有兩人的住宅、車輛、個人物品和共同資產中的一定款項。根據醫療補助計畫在 2020 年的規定，共同生活之配偶得以保有 $74,820 以上、$128,640 以下之資產，以及每月 $3,216 的收入。然而，當夫妻兩人都處於居家護理的狀態時，共同生活之配偶保障便不適用。

依照法律，各州必須採行遺產收復措施，此為主張擁有去世者包括其住宅之資產的權利，以抵付醫療補助計畫為其所支付的居家或老人院護理。此項主張權利的程序在其配偶或未成年子女在世時不得展開。

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 New York State of Health: The Official Health Plan Marketplace. There are many health insurance options available through the Marketplace in New York City. Marketplace plans offer comprehensive health coverage, and have a cost sharing structure 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 on the basis of 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:

- **Medicaid**: Income up to 138% FPL for those under 65, not blind or disabled. Can apply year-round. There is no resource limit.
- An **Essential Plan**: Income from 138-200% FPL for those under 65. Can apply year-round. There is no resource limit.
- A **"Qualified Health Plan"** (QHP), with or without a federal subsidy; there is no resource limit. Can apply only during the annual open enrollment period, unless you have a qualifying event.

How to apply for coverage through the Marketplace:

- 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 **Medicaid** eligibility. If not eligible for 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. If you are not eligible for a subsidy, you can 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 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.

紐約州衛生署／健康保險交易所

- **針對 65 歲以下、非盲、非殘之個人的醫療補助**
- **基本計畫**
- **合格的保健計畫**

健康保險交易所 (Health Insurance Exchange) 是專為購買健康保險而設的市場。在紐約州，交易所的名稱為「紐約州衛生署：官方健康保險市場」。紐約市健保市場提供眾多健康保險選項。市場計畫提供全面的健康保險，且具有費用分攤結構，可能包括保費、自付額、共付額，以及自付費用最高限。透過該健保市場提供保障的所有計畫均為 HMO，這是最具限制性形式的管理式護理。在紐約市，必須挑選在您所居住的行政區提供服務的計畫。

根據聯邦平價醫療法，不得因已經存在的病症而拒絕提供健康保險，不能對那些患有這類病症之人增加收費來提供健康保險，並且對於已經存在的病症不可有接受醫療護理的等候期。上述規定適用於透過健保市場購買或並非在健保市場購買的保險計畫。

紐約州衛生署評估以下健康保險類型的資格條件：

- **醫療補助**：對於那些年齡未滿 65 歲、非盲或非殘障之人，收入不超過 FPL 的 138%。整年可以申請。沒有資產限制。
- **基本計畫**：對於那些未滿 65 歲的人，收入為 FPL 的 138-200%。整年適用整年可以申請。沒有資產限制。
- 「**合格的保健計畫**」(QHP) - 有或無聯邦補助；沒有資產限制。只能在年度開放參加期內申請，除非您有符合資格的事件。

如何透過健保市場申請保險：

- 線上申請：www.nystateofhealth.ny.gov。
- 透過導引者取得免費申請協助。造訪 https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations 以取得紐約的導引者清單。
- 致電紐約州客戶保健服務中心電話：1-855-355-5777。

紐約州衛生署將會首先對您進行**醫療補助**資格評估。如果不符合醫療補助資格，將會對您進行**基本計畫**評估。若不符合基本計畫資格，則會對您進行**合格的保健計畫 (QHP)** 評估。有些人符合聯邦補助資格以購買 QHP。若您不符合領取補助的資格，您可能須全價購買該計畫。您必須是居住在紐約的公民或合法永久居民，才可以透過紐約健保市場購買保險計畫。

健保市場計畫與其他保險如何相互作用？

- 如果已有醫療補助，便不需要再購買其他健康保險。
- 如果已有聯邦醫療保險，也不需要透過健保市場購買健康保險。擁有聯邦醫療保險者一般不能參加健保市場提供的保險計畫。聯邦醫療保險受益人不能取得聯邦補貼以購買保險計畫。

- 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.

MEDICAID FOR PEOPLE UNDER 65, NOT BLIND OR DISABLED
Pregnant women, children up to age 18, parents/caretaker relatives, and childless adults ages 19-64 are evaluated for Medicaid eligibility under MAGI (Modified Adjusted Gross Income) budgeting. Those with incomes up to 138% FPL, estimated at $1,467 monthly for individuals/$1,982 for couples in 2020, may qualify for Medicaid. Children up to age 19 can qualify for 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. Medicaid recertification happens annually. You must respond to mailings in order to be evaluated for ongoing Medicaid benefits.

Individuals who are determined 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 Medicaid through the Marketplace when I become Medicare eligible due to turning 65 or due to disability?
Individuals with Medicaid through the Marketplace cannot maintain Marketplace coverage when they turn 65 or get Medicare due to disability, though the transition process differs depending on whether you get Medicare due to age or disability. **Exception: Parents/Caretaker relatives of minor children are allowed to maintain 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 36).

- **Medicare eligible at 65:** As one approaches 65, one's Medicaid case is transferred to the NYC Human Resources Administration (HRA). HRA will mail forms to be completed to assess whether the individual can remain on Medicaid at the lower, non-MAGI levels. Clients should respond to any HRA mailings if they wish to be assessed for ongoing Medicaid eligibility. HRA will give the individual approximately four months of Medicaid eligibility while the assessment takes place. During this time, clients can use their NYS Benefits Card and access fee-for-service Medicaid from any provider who accepts Medicaid.

  Those collecting Social Security benefits will automatically be enrolled in Medicare at age 65. For those not collecting Social Security benefits at 65, it is recommended that they apply for Medicare during their 7-month Initial Enrollment Period (see page 5), since applying for Medicare is a condition of having Medicaid if over 65.

- 若是領取社會安全殘障保險 (SSDI) 並正處於聯邦醫療保險承保開始前的 24 個月等候期內，可能要考慮市場提供的保險計畫。當您符合聯邦醫療保險的資格時，可以取消健保市場的保險計畫。您需要決定如何獲得聯邦醫療保險福利 – 聯邦醫療保險原始計畫還是醫療保險優勢計畫。

針對 65 歲以下、非盲、非殘之人員的醫療補助
對於懷孕婦女、年齡不超過 18 歲之兒童、父母/看護親屬以及年齡介於 19 至 64 歲的無子女成年人，會依據 MAGI（調整後總收入）預算進行醫療補助資格評估。收入不超過 FPL 138% 之人士（2020 年，個人每月預估為 $1,467/已婚夫婦每月預估為 $1,982）就可能符合醫療補助資格。年滿 19 歲之孩童符合醫療補助的較高收入級別資格。沒有資產限制。他們的醫療補助福利將透過管理式醫療計畫 (HMO) 取得，該計畫應於申請時選擇。醫療補助需每年進行一次重新認證。您必須回覆郵件，以便接受後續醫療補助福利評估。

經判定為殘障的人士，包括領取社會安全殘障保險但尚未取得聯邦醫療保險者，以及年齡在 65 歲以上的父母/看護親屬 （即使已有聯邦醫療保險），在 MAGI 水準提高後可能也有資格獲得醫療補助。

當我由於年滿 65 歲或是因爲身心障礙狀況而符合聯邦醫療保險資格時，我透過健保市場參加的醫療補助會發生什麼事？
透過健保市場參加醫療補助的人士，在他們年滿 65 歲或由於身心障礙取得聯邦醫療保險時無法維持健保市場的保障，雖然轉換程序會依據您是否因為年齡或殘障而獲得聯邦醫療保險而有異。**例外情況：未成年兒童的父母/看護親屬可以透過紐約州衛生署維持醫療補助，而且亦可以擁有聯邦醫療保險。**從健保市場參加的醫療補助轉換為聯邦醫療保險的所有個人都能自動領取 D 部分的全額補助（請參閱第 36 頁）。

- **65 歲符合醫療補助的資格：**當個人年滿 65 歲時，其醫療補助個案將會轉介至紐約市人力資源行政部 (HRA)。HRA 將會郵寄待填寫的表格，以評估該個人是否能在更低、非 MAGI 收入水準的標準下繼續取得醫療補助。若客戶希望進行後續醫療補助合格條件評估，則應該回應任何 HRA 郵件。在進行評估期間，HRA 將會給予這個人約四個月的醫療補助資格。在這個時間內，客戶可以使用其紐約州福利卡並從任何接受醫療補助之業者獲得服務費醫療補助。

  領取社會安全福利的個人將在年滿 65 歲時自動被納入聯邦醫療保險。針對年滿 65 歲之時不領取社會安全福利的個人，推薦在 7 個月內的首次參加期（請參照第 5 頁）申請聯邦醫療保險，因為超過 65 歲時，申請醫療補助的條件是有聯邦醫療保險。

If ongoing Medicaid eligibility is denied, one may want to consider joining a Medicare Advantage plan or purchasing a Medigap policy if in Original Medicare. Individuals will have full Extra Help (see page 36) for the remainder of the calendar year, and NY State of Health will refund the Part B premiums for the period the individual continues to have Medicaid coverage.

If Medicaid eligibility is approved, the individual has a choice of how to receive their Medicare and Medicaid benefits (see page 47 for information on how Medicare and Medicaid work together).

- **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. The individual will maintain Medicaid coverage through the end of their 12-month Medicaid authorization period; they will still have Medicaid through the Marketplace, but will use their Medicaid card to access health services, not their HMO plan card. Medicare is their primary health insurer, and Medicaid is their secondary insurance. As their 12-month authorization period comes to an end, the Medicaid case gets transferred from NY State of Health to HRA. HRA will mail forms to evaluate for ongoing Medicaid eligibility. It is advised that the client enroll in a Part D plan that best covers his/her medications; if the client does not select a plan, he/she will automatically be enrolled in a plan.

THE ESSENTIAL PLAN

The **Essential Plan** is for people under age 65 with monthly incomes between 138-200% FPL**,** estimated at $1,467-$2,127 for individuals/$1,982-$2,873 for a household of two in 2020. Those in the Essential Plan can select a Basic Health Program in which to enroll, and will pay either $0 or $20 in monthly premiums. Essential Plan coverage includes inpatient and outpatient care, physician services, diagnostic services and prescription drugs among others. Preventive care such as routine office visits and recommended screenings are free.

Enrollment in the Essential Plan takes place year round.

- Those with incomes 138-150% FPL (monthly incomes estimated at $1,467-$1,595 for individuals/$1,982-$2,155 for a household of two in 2020) pay $0 premium, $0 deductible, and minimal copays for services, with an annual maximum out-of-pocket cost of $200.
- Those with incomes 150-200% FPL (monthly incomes estimated at $1,595-$2,126 for individuals/$2,155-$2,873 for a household of two in 2020) pay $20/month for coverage, $0 deductible, and low copays, with an annual maximum out-of-pocket cost of $2,000.

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 5) and may want to consider supplemental insurance coverage.

如果後續醫療補助資格被否決，當事人可能考慮加入聯邦醫療保險優勢計畫，或是在聯邦醫療保險原始計畫中購買補充險條款。個人將全額獲得當日曆年剩餘時間的額外補助（請參閱第 36 頁），而紐約州衛生署將會退還個人繼續參加醫療補助保險之期的 B 部分保費。

如果醫療補助的資格通過，當事人可以決定如何接收他們的聯邦醫療保險以及醫療補助福利（請參閱第 47 頁，以瞭解聯邦醫療保險及醫療補助如何相互運作）。

- **因殘障而符合醫療保險資格**：在領取 24 個月的社會安全殘障保險 (SSDI) 賠付之後，個人即符合聯邦醫療保險資格，並會自動寄送聯邦醫療保險卡。他們將會維持醫療補助保障直至其 12 個月醫療補助授權期結束；他們將繼續使用透過健保市場參加的醫療補助，但將使用他們的醫療補助卡來使用健康服務，而非 HMO 計畫卡。聯邦醫療保險是其主要健康保險業者，而醫療補助是其副保險。在其 12 個月授權期間結束時，醫療補助案例會從紐約州衛生署移轉至 HRA。HRA 將會寄發表格，評估醫療補助後續資格。建議客戶登記參加最能保障其藥物的 D 部分計畫；若客戶未選擇計畫，其將會自動加入一項計畫。

基本計畫

基本計畫針對的人員年齡未滿 65 歲，月收入為 FPL 的 138-200%，2020 年預計個人為每月收入介於 $1,467-$2,127，已婚夫婦為每月收入介於 $1,982-$2,873。參加基本計畫的人員可以選擇一項要加入其中的基本健保計畫，而且每月支付保費 $0 或 $20。基本計畫保障包括住院病人和門診病人護理、醫生服務、診斷服務和處方藥物等等。預防護理，例如常規診所訪視和推薦的篩查都是免費的。

登記加入基本計畫全年進行。

- 收入為 FPL 的 138-150% (預計 2020 年單身人士收入為 $1,467-$1,595/月，兩口之家收入為 $1,982-$2,155/月) 的人員為服務支付 $0 保費、$0 自付額以及最低共付額，年度自付費用最高限為 $200。
- 收入為 FPL 的 150-200% (預計2020 年單身人士收入為 $1,595-$2,126/月，兩口之家收入為 $2,155-$2,873/月) 的人員為服務支付 $20 保費、$0 自付額以及最低共付額，年度自付費用最高限為 $2,000。

符合聯邦醫療保險資格的基本計畫加入者不再符合基本計畫資格。他們將會收到紐約州衛生署的通知，聲明其登記加入行將結束。這些個人應該在其 7 個月的首次參加期內登記加入聯邦醫療保險 A、B 和 D（請參閱第 5 頁），並且可能會需要考慮補充保險。

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 $51,040 for individuals and $104,800 for a family of four in 2020), may be eligible for a Federal subsidy in the form of a tax credit to help pay for the cost of a plan.

Plans are divided into **four "metal" tiers** – bronze, silver, gold, and platinum. The metal tiers have different cost-sharing (deductibles, co-pays) requirements; Bronze plans have lower monthly premiums and higher cost-sharing requirements; Platinum plans have higher monthly premiums and lower cost-sharing requirements.

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 at least 14 days before they want their coverage to end (timed to the start of their Medicare benefits). 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 5 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.

合格的保健計畫

合格的保健計畫可供任何人購買；收入低於聯邦貧窮線的 400%（2020 年單身人士收入為 $51,040，四口之家收入為 $104,800），便可能有資格獲以稅收抵免的形式取得聯邦補貼，以幫忙支付保險計畫的費用。

保險計畫區分為**四種「金屬」等級** – 銅、銀、黃金、白金。各金屬等級的費用分攤（自付額、共付額）條件各異；銅計畫的月保費較低而要求的費用分攤較高；白金計畫的月保費較高而要求的費用分攤較低。

我何時可以登記加入合格的保健計畫？

該市場的**開放登記**時間為每年 11 月 1 日至隔年 1 月 31 日。在 1 月 31 日之後，您需等到下一年度的開放登記方可加入。某些特定例外狀況容許於年中登記加入，包含喪失目前的健康保險。

進一步瞭解健保市場計畫的各種途徑：

- 聯絡「導引者」。導引者屬於社區組織，他們能協助您挑選並登記加入保險計畫。欲尋找附近的導引者，請至 https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations 或致電社區健康維護者 (Community Health Advocates)：1-888-614-5400。
- 聯絡紐約州衛生署（由 Maximus 運營），電話：1-855-355-5777，週一至週五上午 8 時至下午 5 時。
- 造訪 nystateofhealth.ny.gov。

一般建議**參加合格的保健計畫 (QHP) 且有資格申請聯邦醫療保險的人士**一旦符合資格即登記加入聯邦醫療保險，並且至少提前 14 天通知他們的計畫退出 QHP（與開始他們的聯邦醫療保險福利同步）。這是因為：

- 具備參加聯邦醫療保險資格後不能繼續領取任何保費補貼或減少費用分攤（以幫助支付 QHP 保費）。
- 加入 QHP 並不能延長其登記加入聯邦醫療保險的時間。延遲登記會造成保險無法銜接以及面臨延遲加入罰金。

受益人須在首次參加期登記加入聯邦醫療保險 A、B 與 D 部分（請參閱第 5 頁以取得詳細資訊），並且須停止 QHP 保險。

可能需要認真考慮 QHP 與聯邦醫療保險的人士有：

- 不具備加入免保費 A 部分資格的人士。他們可能領取保費補貼或減少 QHP 保險的費用分攤，但是僅限他們不登記加入 A 或 B 部分的情況。如果他們希望以後才加入聯邦醫療保險，就會有延遲，並且延遲加入聯邦醫療保險 A 和 B 部分均有延遲登記罰金。
- 年齡未滿 65 歲且患有末期腎臟疾病的人士。

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. The number of Veterans who can be enrolled in health care program is determined by the amount of money Congress gives the VA each year. Since funds are limited, VA set up Priority Group (1-8), based on service history and financial information, to make sure certain groups of Veterans are able to be enrolled before others.

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. Elimination of the consideration of net worth for VA health care enrollment means that certain lower-income, non-service-connected Veterans will have less out-of- pocket costs. To learn more about VA national income thresholds and to calculate your specific geographic-based means test (GMT), visit www.va.gov/healthbenefits/apps/explorer/AnnualIncomeLimits/HealthBenefits.

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

Types of Copayments:

1. **Medication**: Copayments are broken down into three tiers with different cost-sharing: Tier 1, preferred generics - $5; Tier 2, non-preferred generics - $8; and Tier 3, brand name medications - $11. All charges are for up to a 30-day supply of maintenance medications provided on an outpatient basis for non-service-connected conditions for Veterans in Priority Group 2 through 8, with an annual copayment cap of $700, unless otherwise exempted.
2. **Outpatient**: Copayments for primary care visits are $15 and $50 for specialty care visits.
3. **Inpatient:** In addition to a standard copay charge for each 90 days of care within 365 day period regardless of the level of service, a per diem (daily) charge will be assessed for each day of hospitalization
4. **Long Term Care**: VA charges for Long Term Care Services vary by type of service provided and the individual veterans' ability to pay. They are based on three levels of care. Inpatient (Nursing Home, Respite, and Geriatric Evaluation); Outpatient (Adult Day Health Care, Respite, Geriatric Evaluation); and Domiciliary.

VA cannot bill Medicare, so veterans with Medicare-only who are responsible for the co-pay for medical care will receive the appropriate charge for services. However, if there is a supplemental policy, the VA will bill the carrier first.

退伍軍人的保險福利與軍人醫療保險 (TRICARE FOR LIFE)

欲在由退伍軍人事務部 (VA) 所經營之機構接受醫療護理，退伍軍人必須向退伍軍人事務部登記。退伍軍人隨時都可以申請保險。可以加入醫療護理計畫的退伍軍人的人數由國會每年撥付給退伍軍人事務部 (VA) 的金額決定。由於資金有限，VA 根據服務年資和財務狀況設定了優先小組 (1-8)，以確保某些退伍軍人群體能夠優先加入。

登記加入的退伍軍人不需要提交他們的收入資訊。但是，某些退伍軍人需要填寫一份財務狀況評估，以判定他們是否有資格享受免費醫療護理、藥物和/或旅行補貼。

從 2015 年起，VA 不再將資產淨值作為健康護理計畫和共付額承受能力的確定因素。VA 現在只考慮退伍軍人的家庭毛收入和上一年的自付總額。VA 健康護理計畫取消資產淨值這一考量因素意味著某些低收入、患有非服役造成的疾病的退伍軍人的自付費用會降低。欲進一步瞭解 VA 全國性收入門檻，並測算適用於您的地區經濟狀況調查 (GMT)，請造訪 www.va.gov/healthbenefits/apps/explorer/AnnualIncomeLimits/HealthBenefits。

不具免費醫療護理資格的退伍軍人須支付共付額。

共付額類型：

1. **藥物**：共付額分為三個級別，但費用分攤條件互異：1 級，優選非原廠等同藥 – $5；2 級，非優選非原廠等同藥 – $8；3 級，原廠品牌藥 – $11。針對優先團體 2 至 8 號的退伍軍人，因非服役造成的疾病而在門診所獲得的最大供給量為 30 天維護性藥物，年度共付額上限為 $700，除非另有豁免規定。
2. **門診病人**：普通醫療門診共付額為 $15，專科醫療門診共付額為 $50。
3. **住院病人**：無論何種服務等級，一年 365 天內的每 90 天護理適用標準共付額付費政策，除此以外，還會評估住院的每日 (每天) 費用。
4. **長期護理**：退伍軍人事務部對長期護理服務的收費視所提供的服務類別和退伍軍人個人的付款能力而定。基於三個護理等級。住院（老人護理院、臨時看護所、老人檢查院）；門診 (成人日間健康護理、臨時看護所、老人檢查院）；和退伍軍人收容所。

退伍軍人事務部不能向聯邦醫療保險收費，因此只擁有聯邦醫療保險且必須為醫療護理負擔共付額的退伍軍人，將需要為服務支付適當費用。不過，若有補充保險，退伍軍人事務部將會先向該承保業者收費。

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 you may need during your stay.

VA Dental Insurance Program (VADIP)
VA currently provides comprehensive dental benefits to certain eligible veterans. However, there are many veterans who have not been able to access VA dental services due to lack of eligibility. The VA has partnered with two dental insurers, whereby veterans enrolled in the VA health care program and CHAMPVA program beneficiaries can purchase dental insurance. The dental plans have monthly premiums and copayments. For more information, go to www.va.gov/healthbenefits/vadip/ or call Delta Dental at 1-855-370-3303 or MetLife at 1-888-310-1681.

How do VA benefits interact with Medicare Part A and Part B?
Medicare Part A and Part B work independent from the VA health system. For this reason, those eligible for Medicare may want to enroll to have use hospitals and providers outside of the VA health care system. If you don't enroll in Medicare when first eligible, and you are not eligible for a Special Enrollment Period, you 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 as well as VA drug coverage. If one chooses to forego Part D and then later wishes to enroll in Part D, there will be no penalty for late enrollment. However, one 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 the individual qualifies 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 veteran is disabled, and National Guards/Reservist members. Military retirees (and their spouses) having served at least 20 years who 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 managed health care plan that acts as a supplement to Medicare and includes the TRICARE Express Script Pharmacy program. TRICARE Express Scripts does not cover beneficiaries with a primary commercial pharmacy insurance or Medicare Part D coverage. TFL can be used at the VA but since the VA cannot bill Medicare, the patient is responsible for paying Medicare's portion of the bill. For more information on TRICARE for Life call 1-866-773-0404 or visit www.tricare.mil. An additional benefit of TRICARE is their dental benefit. TRICARE dental benefits consist of: TRICARE Active Duty Dental Program (ADDP) for Active Duty Service Members who are referred by a military dental clinic (MDC) or who lives more than 50 miles from a MDC, the TRICARE Dental Program (TDP) for ADSM's families, National Guard/Reservist and their family members and the TRICARE Retiree Dental Program (TRDP) is for retired SM's and families.

在某些情況下，VA 可以預先授權在非 VA 醫院或其他護理環境中的服務。退伍軍人可能需要針對非服役造成的護理支付 VA 共付額。如果並非所有服務都由VA 授權獲得保障，聯邦醫療保險可能會支付您住院期間所需之其他服務的費用。

VA 牙醫保險計畫 (VADIP)
VA 目前對符合資格的部分退伍軍人提供綜合牙醫保險賠付。不過，有許多退伍軍人因資格不符而無法取得 VA 牙科服務。VA 已與兩家牙醫保險業者合作展開一項試辦計畫，參加 VA 健保計畫的退伍軍人和 CHAMPVA 計畫的受益人可以購買牙醫保險。牙醫保險計畫須支付月保費和共付額。欲取得更多資訊，請至 www.va.gov/healthbenefits/vadip/ 或致電 Delta Dental：1-855-370-3303 或 MetLife：1-888-310-1681。

VA 福利與聯邦醫療保險 A 部分及 B 部分如何交互運作？
聯邦醫療保險 A 部分及 B 部分與 VA 健康系統會獨立作業。基於此原因，符合參加聯邦醫療保險資格的人可以登記加入，以使用 VA 健康護理系統以外的醫院及醫療服務提供者。如果您在首次符合資格時未登記加入聯邦醫療保險，而且您不符合特定參加期的資格，則可能需要為 B 部分延遲登記罰金負責。

VA 藥品保險與聯邦醫療保險 D 部分如何交互運作？
VA 處方藥保險被認為是可信的，這表示它不亞於、或更優於聯邦醫療保險 D 部分。同時擁有 D 部分計畫及 VA 藥品保險是可行的。若是原先選擇放棄 D 部分計畫，而日後想要加入 D 部分，將不會有延遲登記罰金。但是，必須等到下一年度的開放參加期（10 月 15 日 – 12 月7 日）才能加入某項保險計畫（承保從 1 月 1 日開始），除非該個人符合加入某個特定參加期的資格。

TRICARE 軍人醫療保險為現役軍人及其家屬、因公殉職的軍人家屬、生前配偶、退休人員及其家屬（不論退伍軍人是否殘障）以及國民衛隊/後備軍人成員提供保險。65 歲以上（含）且服務 20 年以上的軍方退休人士（及其配偶），目前參加聯邦醫療保險 A 部分和 B 部分計畫者，有資格參加 TRICARE for Life (TFL)。TFL 是免保費的管理式健保計畫，用以補充聯邦醫療保險之不足，並且包含 TRICARE 快捷藥方藥房計畫。TRICARE 快捷藥方不保障投保主要商業藥房保險或聯邦醫療保險 D 部分保險的受益人。TFL 可用於退伍軍人事務部的醫療機構，但由於退伍軍人事務部不能向聯邦醫療保險收費，患者有責任支付帳單中的聯邦醫療保險部分。欲進一步瞭解軍人醫療保險，請致電 1-866-773-0404 或造訪 www.tricare.mil。TRICARE 的額外福利是其牙科保險。TRICARE 牙科保險包含：TRICARE 現役牙科計畫 (ADDP) 針對現役服務會員由軍事牙科診所 (MDC) 引薦或住處距離 MDC 超過 50 英里；TRICARE 牙科計畫 (TDP) 針對 ADSM 家庭，國民衛隊/預備役軍人及其家庭成員，而 TRICARE 退役人員牙科計畫 (TRDP) 針對退休的 SM 及家庭。

Civilian Health and Medical Program (CHAMPVA) is a health insurance program for dependents of 100% permanently and totally disabled veterans with a service-connected disability. CHAMPVA has an annual deductible or $50 per person or $100 per family per calendar year. In addition, there is a 25% co-insurance. CHAMPAVA does not maintain a provider listing. Most Medicare and TRICARE providers will also accept CHAMPVA (but be sure to ask the provider). If eligible for TRICARE, one cannot be enrolled in CHAMPVA. For more information on CHAMPVA, you can 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.

平民健康醫療計畫（CHAMPVA）是為服役期间造成的 100% 永久性完全殘障的退伍軍人受撫養親屬所設的醫療保險計畫。CHAMPVA 訂有年度自付額，每一日曆年個人為 $50 或全家為 $100。另外，還有 25% 共保額。CHAMPVA 並無醫療業者一覽表。大部分聯邦醫療保險和 TRICARE 的醫療業者都會接受 CHAMPVA（但務必先向醫療業者確認）。符合 TRICARE 資格者不能參加 CHAMPVA。欲進一步瞭解 CHAMPVA，可致電退伍軍人事務部：1-800-733-8387，或造訪 www.va.gov。

欲進一步瞭解健康退伍軍人事務部保險福利，請致電 1-877-222-8387（中部時間上午 7 時至下午 7 時開通）或造訪 www.va.gov/hac。

OTHER HEALTH COVERAGE OPTIONS FOR NEW YORKERS

COBRA

Federal law requires employers with 20 or more employees to offer COBRA as "continuation coverage" of employer-based health care coverage after you leave your job. 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 as a result of the death or divorce from your actively working spouse. Election of continued coverage must take place within 60 days of the notification of COBRA rights. Premiums for COBRA are 102% of what the employer and employee together pay for the plan. 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.

HHC Options

HHC Options is a program through the NYC Health + Hospitals that allows 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 only pay when you access care. HHC does not look at immigration status when determining eligibility. For more information, visit http://www.nychealthandhospitals.org/paying-for-your-health-care/hhc-options or call 1-844-NYC-4NYC.

Federally Qualified Health Centers

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

紐約居民的其他醫療保險選項

COBRA

聯邦法令規定，員工人數在 20 人（含）以上之雇主，必須在員工離職後提供 COBRA 作為雇主健康保險的「延續保障」。在紐約州，大多數人獲得的 COBRA 保障最高可達 36 個月。COBRA 可銜接缺口，直到您取得聯邦醫療保險或找到提供醫療保險的新工作。若有下列情況即符合此項保險資格：退休、離職、解雇、工時刪減，或是從事工作的配偶死亡或離婚。對延續保障的選擇必須在發出 COBRA 權益通知的 60 天內進行。COBRA 的保費是雇主和員工兩方付予該計畫合計金額的 102%。配偶和受撫養親屬也可以享有 COBRA 的保險福利。

若在符合聯邦醫療保險資格之前享有 COBRA，當聯邦醫療保險開始生效時，COBRA 一般即會終止。若是已經符合聯邦醫療保險的資格，並且仍在工作，可在停止工作時選擇 COBRA。若是同時擁有聯邦醫療保險和 COBRA，聯邦醫療保險為主保險，COBRA 為副保險。COBRA 保險不允許當事人延後加入 B 部分，延後會產生罰則。

健康和醫院機構保險 (HHC Options)

「健康和醫院機構保險」是由紐約市健康及醫院所提供的計畫，讓中低收入的個人和家庭能夠透過 HHC 的醫院和醫療設施網絡，按遞減的收費標準來取得醫護服務。參加「健康和醫院機構保險」無需任何費用；只有使用醫療服務時才要付費。HHC 在進行資格認定時並不會查看移民身份。如需詳細資訊，請造訪 http://www.nychealthandhospitals.org/paying-for-your-health-care/hhc-options 或致電 1-844-NYC-4NYC。

聯邦合格保健中心

聯邦合格保健中心 (FQHC) 是向所有年齡層次之人士提供普通醫療（健康和疾病門診）、心理健康及藥物濫用、牙科護理及處方藥物的綜合保健中心。聯邦合格保健中心 (FQHC) 接納健康保險，且視病患並無按遞減標準收費（病患按照各自收入支付保費）的保險。對於聯邦醫療保險受益人，FQHC 可免除 B 部分的年度自付額和 20% 的共保額（若合資格）。若要尋找 FQHC，請造訪 http://findahealthcenter.hrsa.gov/Search_HCC.aspx。

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 resources to explore whether or not group plans may be available to you.

Small Business Service Bureau	Small business employee	1-800-343-0939 www.sbsb.com
Graphic Artists Guild	Graphic Artists	1-212-791-3400 graphicartistsguild.org
National Writers Union	Writers	1-212-254-0279 www.nwu.org
Screen Actors Guild	Performers	1-212-944-1030 www.sagaftra.org
Freelancer's Union	Financial Services Nonprofits Technology Media & Advertising Arts, Culture or Entertainment Domestic Child Care Giver Traditional or Alternative Health Care Provider Skilled Computer User	www.freelancersunion.org

健康保險與自雇

有些行業提供團體費率的保險。請洽詢您的前任雇主和/或任何您所屬的專業協會。
以下提供一些資源，可查詢是否有適合您的團體計畫。

小企業服務局 (Small Business Service Bureau)	小企業員工	1-800-343-0939 www.sbsb.com
平面藝術家協會 (Graphic Artists Guild)	平面藝術家	1-212-791-3400 graphicartistsguild.org
全國作家聯盟 (National Writers Union)	作家	1-212-254-0279 www.nwu.org
演員工會 (Screen Actors Guild)	表演工作者	1-212-944-1030 www.sagaftra.org
自由工作者聯盟 (Freelancer's Union)	金融服務 非營利事業 科技媒體 與廣告藝術、 文化或娛樂 家庭托兒業者 傳統或另類醫療業者 專業電腦用戶	www.freelancersunion.org

ADVANCE DIRECTIVES

Your Right to Make Health Care Decisions Under the Law

You have the right to make your own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatments, you should make these wishes known to your doctor, hospital or other health care providers. You have the right to be told the full nature of your illness, including proposed treatments, any alternative treatments, and the risks of these procedures.

You need to speak with your spouse, family members, close friends and your doctor to help you decide whether you want an advance directive. Discuss with them, in advance, what your personal directions for your care would be.

An advance directive is a document that states your choices about medical treatment. In New York, there are three kinds of advance directives:

1. A Health Care Proxy allows you to appoint another person to make medical decisions for you should you become unable to make those decisions yourself. The "agent" you select needs to be clear about your wishes for treatment, be available if sudden choices need to be discussed, and agree to accept the responsibility if the situation arises. Typically, your doctor or hospital staff cannot be your "agent."
2. A Living Will allows you to explain your health care wishes and can be used to specify wishes regarding life-sustaining treatments or procedures administered to you if you are in a terminal condition or a permanent unconscious state. The document must be signed, dated and witnessed (but not by your doctor or a close relative).
3. A Do Not Resuscitate (DNR) Order allows you to specify that you do not want CPR should your heart or breathing stop.

Advance directives should be available in an emergency. Do not put them in a safe deposit box. Give a copy to each of your doctors and to the family member who might be your "agent." A copy is as good as an original. These forms are available at hospitals, doctor's offices and from state offices at www.ag.ny.gov. The forms are free and do not require a lawyer to complete.

> Under the Family Health Care Decisions Act, family members or a close friend can act as surrogate to make health care decisions, including withholding or withdrawal of life sustaining treatments on behalf of patients who have lost their ability to make such decisions and have not prepared advance directives regarding their wishes. Even with this new law, New Yorkers are encouraged to prepare a health care proxy which allows the person you appoint, called your "health care agent" to make health care decisions for an individual who loses the capacity to express those choices. Your agent must be aware of your wishes about nourishment and water through feeding tubes and IV lines.

預立醫療指示

法律所規定的個人醫療護理決定權

您有權利決定自己的醫療護理，包括接受、拒絕或停止何種醫療護理或治療。若是不想接受某種類型的治療，應該告知您的醫生、醫院或其他醫護業者。您有權利獲知所患疾病的全部詳情，包括：提議的治療方案、任何替代療法，以及這些過程所含有的風險。

您需要與配偶、家人、密友及醫生討論，以協助您決定是否應預立醫療指示。與他們預先討論，您對自己的醫療護理會有哪些個人指示。

預立醫療指示是一份文件，記錄您對醫療的選擇。在紐約，有三種預立醫療指示：

1. 醫療護理授權書 (Health Care Proxy) 讓您指定他人在您無法自行做決定時代您做出醫療決定。您所選擇的「代理人」必須清楚您對治療的期望，需要討論突發性抉擇時能夠取得連繫，並且同意在任何情況發生時能承擔責任。在一般情況下，您的醫生或醫院的工作人員不能成為您的「代理人」。
2. 生前預囑 (Living Will) 讓您能說明自己對醫療護理的期望，並可用於特別說明關於使用維生設備延長生命、或是在臨終或永久無意識狀態時所希望接受的處理程序。該份文件必須簽名、註明日期並有人證 (但不得為您的醫生或近親)。
3. 不施行心肺復甦術 (DNR) 指示讓您能特別指明一旦心臟或呼吸停止時，您不希望施行心肺復甦術。

預立醫療指示應該在緊急情況時可以取得。切勿把它們放在保險箱內。給您的醫生和可能成為您的「代理人」的家庭成員每人一份副本。副本和正本的效力是一樣的。這些表格可在醫院、醫生診所及下列網站上的州辦事處取得：www.ag.ny.gov。表格皆為免費且不需要律師即可填寫。

> 依照最新的家庭醫療決定法，家人或密友能以代理人身份代為做出醫療決定，包括代表喪失決定能力、且未預先準備醫療指示表明態度的病患決定拒絕或撤除維生設備。儘管有這項新法令，建議紐約人士還是應該準備醫療護理授權書，讓指定的「醫療代理人」為失去表達選擇能力者做出醫療決定。代理人必須體察您對經由餵食管和靜脈注射給予營養與水份的意願。

MEDICARE 2020

Part A: Hospital Insurance

Deductible	$1,408 per benefit period
Co-Payment	$352 per day for days 61-90 of each benefit period
	$704 per day for each "lifetime reserve day"
Skilled Nursing Facility Co-Pay	$176 per day for days 21-100 of each benefit period

Part B: Medical Insurance

Monthly Premium	Most Medicare beneficiaries pay the standard premium of $144.60, except for: • Those whose Social Security Cost of Living Adjustment (COLA) didn't increase enough to raise their Part B premiums to the $144.60 level. • Higher income (over $87,000 single/174,000 married) beneficiaries will pay higher amounts.
Annual Deductible	$198
Co-Insurance	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. This is called "premium hospital insurance." In 2020, if you have less than 30 quarters of Social Security coverage, your Part A premium is $458 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium is $252 per month.

Medicare Savings Program (2020 estimate)

	Monthly	
	Individual	**Couple**
QMB - Qualified Medicare Beneficiary NY State pays premiums, deductibles and co- insurance for those who are automatically eligible for Part A.	$1,083	$1,457
SLMB - Specified Low-Income Medicare Beneficiary Levels State pays Medicare Part B premium only.	$1,296	$1,744
QI - Qualifying Individuals State pays Medicare Part B premium only.	$1,456	$1,960

*You can also apply for QMB if you earn less than the above ranges but are not interested in applying for Medicaid.

2020 年聯邦醫療保險

A 部分：住院保險

自付額	$1,408 (每一段權益期)
共付額	每段權益期的第 61 天至 90 天為每日支付 $352
	每一段「終身儲備期」為每日 $704
專業護理設施共付額	每段權益期的第 21 天至 100 天為每日支付 $176

B 部分：醫療保險

每月保費	多數聯邦醫療保險受益人將需要支付 $144.60 的標準保費，除了： • 那些其社會安全生活費用調整 (COLA) 沒有增加得足以將其 B 部分保費提高至 $144.60 水準之人。 • 收入較高的受益人（個人超過 $87,000/已婚夫妻超過 $174,000）需支付較高額的保費。
年自付額	$198
共保額	大部分服務有 20%

有些 65 歲（含）以上人士因不符合社會安全局的條件而無**免保費住院保險**（**A** 部分）。屬於此一類者，可支付月保費以取得 A 部分。此稱之為「保費型住院保險」。在 2020 年，若您的社會安全保險少於 30 個工作季點，A 部分保費將是每月 $458。若您的社會安全保險累積了 30 至 39 個工作季點，A 部分保費將是每月 $252。

聯邦醫療保險免保費計畫（2020 年預估值）

	月收入限制	
	個人	夫妻
QMB — 合格聯邦醫療保險受益人計畫 紐約州為自動符合 A 部分保險計畫資格者支付保費、自付額和共保額。	$1,083	$1,457
SLMB — 特定低收入聯邦醫療保險受益人等級 紐約州僅支付聯邦醫療保險 B 部分保費。	$1,296	$1,744
QI — 合格個人計畫 紐約州僅支付聯邦醫療保險 B 部分保費。	$1,456	$1,960

*如果您的所得低於上述範圍，但是無意申請醫療補助，也可以申請 QMB。

MEDICAID 2020

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

	Monthly Income	Assets
Individual	$875	$15,750
Couple	$1,284	$23,100

*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.

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 in a married couple 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 towards the residential spousal care.

The community spouse is allowed to retain the following:
Resources: $74,820 minimum; $128,640 maximum **Income**: $3,216 monthly

For more information on Medicaid, call HRA's Medicaid Helpline at 1-888-692-6116.

2020 年醫療補助

標準醫療補助
失明、殘障或 65 歲 (含) 以上者的收入與資產最高限*：

	月收入	資產
個人	$875	$15,750
夫妻	$1,284	$23,100

*收入的首 $20 可豁免。以上數字尚未扣除 $20。准予擁有的葬儀金津貼為每人 $1,500。

住在老人院的醫療補助
收入：住在老人院的人士符合領取醫療補助的補貼資格時，除了每個月 $50 的津貼留做其個人需要之用，所有的收入都歸老人院所有。

資產：所有的個人資產都必須先用以支付費用（不包括：主要住宅、汽車和個人物品）。

已婚夫妻：已婚夫妻中之一人符合醫療補助對老人院的補貼時，其配偶（仍居住在家中者）可以保留部分收入和兩人共有之資產，而醫療補助支付接受住宿照護的配偶。

共同生活之配偶得以保有：
資產：$74,820 以上；$128,640 以下 **收入**：每月 $3,216

欲進一步瞭解醫療補助，請致電人力資源管理局 (HRA) 的醫療補助專線 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. Office hours are Monday-Friday, from 9 am – 5 pm.

Citywide Medicaid Office:
- Central Medicaid Office, 785 Atlantic Avenue, Brooklyn, NY 11238 1-929-221-3502

Manhattan
- Metropolitan Hospital: 1901 First Avenue, 1st Floor, Room 1D-27 (97th Street & 2nd Ave. entrance). (212) 423-7006
- Chinatown Medicaid Office: 115 Chrystie Street, 5 floor. (212) 334-6114
- Manhattanville Medicaid Office: 520-530 West 135th Street, 1st floor. (212) 939-0207/0208

Bronx
- North Central Bronx Hospital: 3424 Kossuth Avenue, 1st Floor, Room 1A 05. (718) 920-1070
- Morrisania Diagnostic & Treatment Center: 1225 Gerard Avenue, Basement. (718) 960-2799
- Rider Medicaid Office: 305 Rider Avenue, 4th Floor. (718) 585-7872

Brooklyn
- Coney Island Medicaid Office: 3050 West 21st Street, 3rd Floor. (929) 221-3790
- East New York Medicaid Office: 404 Pine Street, 2nd floor. 718-221-8204
- Kings County Hospital: 441 Clarkson Avenue, "T" Building, Nurses Residence, 1st Floor. (718) 221-2300/2391
- Brooklyn South Medicaid Office (Central Medicaid Office): 785 Atlantic Avenue, 1st Floor. (929) 221-3502

Queens
- Queens Community Medicaid Office: 32-20 Northern Blvd., 3rd Floor. (718) 784-6729
- Jamaica Community Medicaid Office: 165-08 88th Avenue, 8th Floor. (718) 252-3193

Staten Island
- Staten Island Medicaid Office: 215 Bay Street. (929) 221-8823/8824

紐約市醫療補助辦事處

醫療補助申請人可致電醫療補助專線 1-888-692-6116 以查詢距離最近的醫療補助辦事處、營業時間和前往指示。紐約市居民可以在五個行政區內的任何辦事處申請。營業時間是星期一至星期五上午 9 時至下午 5 時。

全市醫療補助辦事處：
- 醫療補助中央辦公室 (Central Medicaid Office), 785 Atlantic Avenue, Brooklyn, NY 11238 1-929-221-3502

曼哈頓
- 大都會醫院 (Metropolitan Hospital)：1901 First Avenue, 1st Floor, Room 1D-27 (97th Street & 2nd Ave. 入口)。(212) 423-7006
- 華埠醫療補助辦事處：115 Chrystie Street, 5 floor。(212) 334-6114
- 曼哈頓醫療補助辦事處：520-530 West 135th Street, 1st floor。(212) 939-0207/0208

布朗士區
- 布朗士中北區醫院 (North Central Bronx Hospital)：3424 Kossuth Avenue, 1st Floor, Room 1A05。(718) 920-1070
- Morrisania 診斷和治療中心：1225 Gerard Avenue, Basement。(718) 960-2799
- Rider 醫療補助辦事處：305 Rider Avenue, 4th Floor。(718) 585-7872

布魯克林區
- 康尼島醫療補助辦事處：3050 West 21st Street, 3rd Floor。(929) 221-3790
- 東紐約區醫療補助辦公室：404 Pine Street, 2nd floor。718-221-8204
- 國王郡醫院 (Kings County Hospital)：441 Clarkson Avenue, “T” Building, Nurses Residence, 1st Floor。(718) 221-2300/2391
- 布魯克林醫療補助南部辦公室（醫療補助中央辦公室）：785 Atlantic Avenue, 1st Floor。(929) 221-3502

皇后區
- 皇后區社區醫療補助辦事處：32-20 Northern Blvd., 3rd Floor。(718) 784-6729
- 牙買加社區醫療補助辦事處：165-08 88th Avenue, 8th Floor。(718) 252-3193

史坦登島
- 史坦登島醫療補助辦事處：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 2020

2018 Modified Adjusted Gross Income (MAGI)	Part B Monthly Premium	Part D (Prescription Drug) Monthly Premium
Individuals with a MAGI of $87,000 or **less**/ Married couples with a MAGI of $174,000 or **less**	2020 Standard Premium = $144.60	Your Plan Premium
Individuals with a MAGI $87,000-$109,000/ Married couples with a MAGI $174,000-$218,000	$202.40	Your Plan Premium + $12.20
Individuals with a MAGI $109,000-$136,000/ Married couples with a MAGI $218,000-$272,000	$289.20	Your Plan Premium + $31.50
Individuals with a MAGI $136,000-$163,000/ Married couples with a MAGI $272,000-$326,000	$376.00	Your Plan Premium + $50.70
Individuals with a MAGI $163,000-$500,000/ Married couples with a MAGI $326,000-$750,00	$462.70	Your Plan Premium +$70.00
Individuals with a MAGI **greater than $500,000/** Married couples with a MAGI **greater than $750,000**	$491.60	Your Plan Premium $76.40
Married filing separately with a MAGI less than $87,000	$144.60	Your plan premium
Married filing separately with a MAGI $87,000-$413,000	$462.70	Your Plan Premium +$70.00
Married filing separately with a MAGI $413,000 and greater	$491.60	Your Plan Premium $76.40

- The Part B Premium, as well as IRMAA for Part B and Part D are deducted from one's Social Security benefit (or billed, if not collecting Social Security benefits).
- The Part D surcharge is deducted from one's Social Security check (or billed, if not collecting Social Security benefits), even if one pays the premium directly to the plan.

2020 年聯邦醫療保險 B 部分及 D 部分為較高收入聯邦醫療保險受益人之月收入相關調整額 (IRMAA)

2018 年修正調整後年總收入 (MAGI)	B 部分月保費	D 部分（處方藥）月保費
個人 MAGI 為 $87,000 或以下／已婚夫妻 MAGI 為 $174,000 或以下	2020 年標準保費 = $144.60	您的保費
個人 MAGI 為 $87,000-$109,000/ 已婚夫妻 MAGI 為 $174,000-$218,000	$202.40	您的保費 + $12.20
個人 MAGI 為 $109,000-$136,000/ 已婚夫妻 MAGI 為 $218,000-$272,000	$289.20	您的保費 + $31.50
個人 MAGI 為 $136,000-$163,000/ 已婚夫妻 MAGI 為 $272,000-$326,000	$376.00	您的保費 + $50.70
個人 MAGI 為 $163,000-$500,000/ 已婚夫妻 MAGI 為 $326,000-$750,00	$462.70	您的保費 +$70.00
個人 MAGI **超過 $500,000/** 已婚夫妻 MAGI **超過 $750,000**	$491.60	您的保費 $76.40
已婚但分別保稅 MAGI 少於 $87,000	$144.60	您的保費
已婚但分別保稅 MAGI 為 $87,000-$413,000	$462.70	您的保費 +$70.00
已婚但分別保稅 MAGI為$413,000 及更多	$491.60	您的保費 $76.40

- B 部分保費以及 B 部分及 D 部分的 IRMAA 已從當事人社會安全福利中減免（或是已支付，如未享有社會安全福利）。
- D 部分附加費用已從當事人的社會安全支票中減免（或是已支付，如未享有社會安全福利），即便當事人直接向計畫付款。

Helpful 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.
Co-insurance	An amount that you must pay for medical care. It is a percentage of the total cost of care.
Co-payment	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)	People with higher incomes are required to pay higher premiums for Medicare Part B and Part D.
Pre-existing Condition	A health problem 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 which must be obtained beforehand in order for an insurance company to cover a medication or service.
Quantity Limits	When Part D drug plans limit the amount of a prescription medication that they will cover in a certain period of time due to safety and/or cost reasons.
Step Therapy	A restriction used by a Part D drug plan, requiring you to first try one drug before covering another drug for that condition.

有用的健康保險定義

原廠品牌藥	具有商品名稱並且受專利保護的藥物。只能由擁有專利的公司進行生產和銷售。
共保額	必須為醫療護理支付的一筆金額。總護理費用百分比。
共付額	支付醫療服務的一筆固定金額。
可信的保險保障	一種與基本聯邦醫療保險 D 部分藥物計畫相比一樣好，甚至更好的處方藥保險。
自付額	每年必須在保單開始支付之前支付的一筆金額。
具雙重資格者	同時享有聯邦醫療保險和醫療補助的某個人。
聯邦貧窮線 (FPL)	每年由聯邦政府簽發的收入尺度。用於判定某些計畫和福利之合格條件的數額。
處方集	處方藥物計畫承保藥物之清單。
非原廠等同藥	其活性成分配方相同於原廠品牌藥的一種藥物。非原廠等同藥的費用通常低於原廠品牌藥。
收入相關醫療保險調整額 (IRMAA)	就醫療保險 B 部分和 D 部分而言，收入較高的人源需要支付較高的保費。
先前存在的病情	一種在保險保障生效之前就存在的健康問題。
保費	為保險而支付的金額。不管是否使用任何健保服務，您均應支付保費。
事先授權	必須事先取得的核准，以便保險公司給藥物或服務承保。
數量限制	此種情況下所指的是 D 部分藥物計畫限制處方藥的數量，其中藥物計畫將會由於安全性和/或費用原因在某個時段給這些藥物承保。
循序用藥	D 部分藥物計畫所使用的一種限制，要求您在為那種情況使用另一種藥物之前首先試用一種藥物。

Resources for Assistance Paying for Prescription Medications

(Each program can have their own eligibility requirements. Please 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 – This is 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. IDNYC cards can offer the same discount as the BigAppleRx card. Visit www.BigAppleRx.com or call 1-888-454-5602 for more information.

CancerCare Co-Payment Assistance Foundation – Helps eligible individuals with co-payment assistance for chemotherapy and targeted treatment drugs. www.cancercarecopay.org or 1-866-552-6729.

Good Days (formerly Chronic Disease Fund) – Helps people with certain chronic diseases to pay 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 – GoodRx allows you to compare the cost of drugs at different pharmacies. It also allows you to 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 certain medications and therapies. Healthwellfoundation.org or 1-800-675-8416.

Leukemia and Lymphoma Society Co-Pay Assistance Program – Helps pay for insurance premiums (both private and Medicare-related premiums) and co-pays. https://www.lls.org/support/information-specialists or 1-800-955-4572.

Medicine Assistance Tool - Helps people access free or low-cost prescription medications. Also provides links for programs that assist with paying co-payments. www.medicineassistancetool.org.

National Association of Boards of Pharmacies (NABP) – Allows you to search for internet pharmacies that are certified as safe distributors. www.nabp.net

援助支付處方藥的資源

（每項計畫均有自身的資格要求。如欲獲取更多資格要求資訊以及瞭解如何申請，請撥打電話或查看網址。）

ADAP (愛滋病藥物輔助計畫)——為治療 HIV/AIDS 及因免疫系統缺失引起的感染提供免費藥物。ADAP 計畫能夠為擁有部分保險（包括聯邦醫療保險 D 部分）以及有醫療補助抵降保費需求的人士提供幫助。致電 (800) 542-2437 或造訪 www.health.ny.gov/diseases/aids/general/resources/adap/eligibility.htm 以取得詳細資訊。

福利查詢 (Benefits Check Up)——協助找尋適用的福利和服務。www.benefitscheckup.org

BigAppleRx 處方藥折扣卡——是由紐約市政府免費提供的處方藥折扣卡。任何人都能獲得卡片，無論其年齡、收入、公民權和健康保險狀態為何。原廠品牌藥和非原廠等同藥都能享有折扣。紐約市民卡 (IDNYC) 可提供和 BigAppleRx 折扣卡相同的折扣。請造訪 www.BigAppleRx.com 或致電 1-888-454-5602 以取得詳細資訊。

癌症護理共付額援助基金 (CancerCare Co-Payment Assistance Foundation)——為有資格條件的人提供共付額援助，以便進行化療和獲取靶向治療藥物。造訪 www.cancercarecopay.org 或撥打 1-866-552-6729。

好日子 **(Good Days)** **(原慢性疾病基金)**——幫助某些患有慢性疾病的人支付保險共付額。如欲獲取更多資訊以及符合條件的疾病和藥物名稱列表，請造訪 www.mygooddays.org 或致電 1-877-968-7233。

GoodRx——GoodRx 可讓您比較不同藥房的藥物費用。也可讓您列印優惠券。請造訪 GoodRx.com 以取得詳細資訊。

健康基金會 (HealthWell Foundation)——為符合條件的人士提供經濟援助以支付某些藥物和治療的共保額、共付額、健康保險和自付額。造訪 Healthwellfoundation.org 或致電 1-800-675-8416。

白血病和淋巴瘤學會共付額援助計畫 (Leukemia and Lymphoma Society Co-Pay Assistance Program)——幫助支付保費（私人或聯邦醫療保險相關保費均可）和共付額。造訪 https://www.lls.org/support/information-specialists 或致電 1-800-955-4572。

藥物協助工具 (Medicine Assistance Tool)——協助取得免費或低價的處方藥。也提供連結至協助支付共付額的計畫。造訪 www.medicineassistancetool.org。

美國藥事局全國聯合會 (NABP)——可搜尋經認證為安全經銷商的網上藥房。www.nabp.net

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. www.bethematch.org or 1-888-999-6743.

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

NeedyMeds.org – Provides information on medications and patient programs explaining how to apply to each one. www.needymeds.org or 1-800-503-6897.

Patient Advocate Foundation Co-Pay Relief Program – Helps eligible individuals with certain diagnoses to pay copayments for prescription medications. www.copays.org or 1-866-512-3861.

Patient Services Incorporated (PSI) – May be able to assist people with certain chronic conditions by offering assistance with paying health insurance premiums and copayments/co-insurance, as well as costs related to travel. www.patientservicesinc.org or 1-800-366-7741.

RX Hope – Apply for discounted and free medications directly through this website. www.rxhope.com

Other Internet Resources

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

Dental Plan Comparison – www.dentalplans.com

Health and Human Services Administration – www.hhs.gov

HealthFinder.gov – Access information specific to different health conditions

Families USA – Information on health care policy – www.familiesusa.org

Kaiser Family Foundation - Information on health care policy – www.kff.org

國家骨髓病患者援助計畫與經濟援助基金 (National Marrow Patient Assistance Program and Financial Assistance Fund)—如果保險沒有承保全部費用，可幫助符合條件的個人支付骨髓或臍帶血移植的費用。造訪 www.bethematch.org 或致電 1-888-999-6743。

美國罕見疾病組織 (NORD)—協助患有某些疾病、而沒有保險或保險不足的人士取得所需的藥物。www.rarediseases.org 或致電 1-800-999-6673

NeedyMeds.com—提供關於藥物治療與病患計畫的資訊，說明如何申請每一項計畫。造訪 www.needymeds.org 或致電 1-800-503-6897。

患者權益基金會共付額援助計劃—幫助符合條件且被診斷某些疾病的人支付處方藥的共付額。造訪 www.copays.org 或致電 1-866-512-3861。

患者服務企業 (Patient Services Incorporated, PSI)—可幫助患有某些慢性疾病的人提供援助，支付健康保險保費和共付額/共同保險，以及差旅費用。造訪 www.patientservicesinc.org 或致電 1-800-366-7741。

RX Hope—直接通過該網站申請折扣藥品和免費藥品。造訪此網站：www.rxhope.com。

其他網上資源

勞工部—提供關於 COBRA、塵肺症等資訊—www.DOL.gov

牙醫保險計畫比較—www.dentalplans.com

健康與人類服務管理局—www.hhs.gov

HealthFinder.gov—提供不同病症的專門資訊

美國家庭聯盟 (Families USA)—提供關於健保政策的資訊— www.familiesusa.org

凱薩家庭基金會 (Kaiser Family Foundation)—提供關於健保政策的資訊—www.kff.org

RESOURCES

HIICAP Helpline – Call NYC Department for the Aging's Aging Connect and ask for HIICAP 1-212-244-6469
www1.nyc.gov/site/dfta/services/health-insurance-assistance.page

Aging Connect – for services offered by the NYC Department for the Aging........ 1-212-244-6469
www.nyc.gov/aging

Access-A-Ride........ 1-877-337-2017
http://web.mta.info/nyct/paratran/guide.htm

Advocacy, Counseling and Entitlement Services Project (ACES)........ 1-212-614-5552

Attorney General Bureau of Consumer Fraud and Protection........ 1-800-771-7755
www.ag.ny.gov

BigAppleRx Discount Card........ 1-888-454-5602
www.BigAppleRx.com TTY:1-800-662-1220

Center for the Independence of the Disabled in New York........ 1-212-674-2300 or 1-646-442-1520
www.cidny.org

Centers for Medicare and Medicaid Services (CMS)........ 1-800-MEDICARE
www.cms.gov

Columbia University College Of Dental Medicine's Teaching Clinic........ 1-212-305-6100
www.dental.columbia.edu/teaching-clinics

Community Health Advocates........ 1-888-614-5400
www.communityhealthadvocates.org

Eldercare Locator........ 1-800-677-1116
www.eldercare.gov

Elderly Pharmaceutical Insurance Coverage (EPIC)........ 1-800-332-3742
www.health.state.ny.us/health_care/epic/index.htm

HEAR NOW (provides hearing aids to people with limited resources)........ 1-800-328-8602
https://www.starkeyhearingfoundation.org/

Health Information Tool for Empowerment (resource directory of free and low cost health and social services)........ 1-866-370-4483
www.HiteSite.org

Health and Hospitals Corporation (HHC Options)........ 1-844-NYC-4NYC
http://www.nychealthandhospitals.org/paying-for-your-health-care/hhc-options/

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........ 1-800-854-3402
www.hospicefoundation.org

ICAN - Independent Consumer Advocacy Network – Medicaid managed long term care ombudsman........ 1-844-614-8800

LawHelp.org (to search for legal services, including pro bono)

Legal Services NYC........ 1-917-661-4500
www.legalservicesnyc.org

Limited Income Newly Eligible Transition (LINET) Program (administered by Humana)........ 1-800-783-1307

資源

HIICAP 熱線 ──致電紐約州老人局的 Aging Connect 專線並洽詢 HIICAP -------- 1-212-244-6469
www1.nyc.gov/site/dfta/services/health-insurance-assistance.page

Aging Connect ──紐約市老人局提供的服務 -------- 1-212-244-6469
www.nyc.gov/aging

Access-A-Ride 殘障專車 -------- 1-877-337-2017
http://web.mta.info/nyct/paratran/guide.htm

宣導、諮商與權益服務方案 (ACES) -------- 1-212-614-5552

檢察長辦公廳消費者保護局 -------- 1-800-771-7755
www.ag.ny.gov

BigAppleRx 折扣卡-------- 1-888-454-5602
www.BigAppleRx.com 聽障專線:1-800-662-1220

紐約身心障礙人士獨立中心 -------- 1-212-674-2300 或 1-646-442-1520
www.cidny.org

聯邦醫療保險和醫療補助服務中心 (CMS) -------- 1-800-MEDICARE
www.cms.gov

哥倫比亞大學牙醫學院教學診所-------- 1-212-305-6100
www.dental.columbia.edu/teaching-clinics

社區健康維護者 -------- 1-888-614-5400
www.communityhealthadvocates.org

老年保健指南 -------- 1-800-677-1116
www.eldercare.gov

老人藥品保險 (EPIC) -------- 1-800-332-3742
www.health.state.ny.us/health_care/epic/index.htm

HEAR NOW（為資產有限人士提供助聽器）-------- 1-800-328-8602
https://www.starkeyhearingfoundation.org/

自主能力健康資訊工具（免費及低收費保健和社會服務資源目錄）-------- 1-866-370-4483
www.HiteSite.org

健康及醫院總局 (HHC Options) -------- 1-844-NYC-4NYC
http://www.nychealthandhospitals.org/paying-for-your-health-care/hhc-options/

人力資源管理局 (HRA) 資訊專線──提供所有 HRA 計畫的資訊，包括食物券、公共援助和醫療補助 -------- 1-718-557-1399

HRA 醫療補助專線-------- 1-888-692-6116

美國安寧療護基金會-------- 1-800-854-3402
www.hospicefoundation.org

ICAN - 獨立消費者維權網路──醫療補助管理式長期護理調解員-------- 1-844-614-8800

LawHelp.org（搜尋法律服務，包括無償服務）

紐約市法律服務 -------- 1-917-661-4500
www.legalservicesnyc.org

收入有限人士新增資格過渡 (LINET) 計畫（由 Humana 管理）-------- 1-800-783-1307

Livanta, LLC - Quality Improvement Organization to appeal hospital discharge and make 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............ 1-800-333-4114
www.medicarerights.org

National Council on Aging: www.ncoa.org

National Health Information Center: www.health.gov/nhic

New York Connects (long term care services and support; they will make home visits)............ 1-800-342-9871
Bronx (Neighborhood SHOPP): 1-347-862-5200
Brooklyn (JASA): 1-718-671-6200
Manhattan (NY Foundation for Senior Citizens): 1-212-962-2720
Queens (Selfhelp Community Services): 1-718-559-4400
Staten Island (CASC):1-718-489-3954

New York Legal Assistance Group's (NYLAG) Evelyn Frank Legal Resources Program............ 1-212-613-7310
EFLRP@NYLAG.org.

New York State of Health (Marketplace Plan contact)............ 1-855-355-5777
https://nystateofhealth.ny.gov

NYC Department of Health............ 311
www.nyc.gov/health

NYS Long Term Care Ombudsman Program............ 1-855-582-6769
https://ltcombudsman.ny.gov/

NYS Department of Health-Medicaid and Marketplace HMO complaints 1-800-206-8125

NYS Department of Financial Services............ 1-800-342-3736
www.dfs.ny.gov

NYS Medicaid Helpline............ 1-800-541-2831

NYS Office for the Aging Senior Citizen Helpline............ 1-800-342-9871
www.aging.ny.gov

NYS Office of Crime Victim Services............ 1-800-247-8035
https://ovs.ny.gov/help-crime-victims

NYS Department of Health Office of Professional Medical Conduct (physician quality control complaints)............ 1-800-663-6114

NYU Dental Clinic............ 1-212-998-9800
www.nyu.edu/dental

Railroad Retirement Board............ 1-877-772-5772
www.rrb.gov

SMP (formerly Senior Medicare Patrol) to report Medicare fraud/abuse in NYS............ 1-800-333-4374

Social Security Administration............ 1-800-772-1213
www.socialsecurity.gov TTY 1-800-325-0778

United States Department of Veterans Affairs............ 1-800-827-1000
www.va.gov

Livanta, LLC——品質改善機構向醫院進行出院申訴並對醫護品質提出投訴. 1-866-815-5440

醫療補助促進的年長、眼盲及殘障加入者（還可以協助聯邦醫療保險免保費計畫申請）------------ 1-347-396-4705

醫療補助詐騙控制單位 (Medicaid Fraud Control Unit)（紐約檢察長）---- 1-800-771-7755

聯邦醫療保險詐騙熱線（稽核長辦公室，DHHS）------------ 1-800-447-8477

聯邦醫療保險熱線 ------------ 1-800-MEDICARE

聯邦醫療保險權益中心------------ 1-800-333-4114
www.medicarerights.org

美國老年人理事會：www.ncoa.org

國家健康資訊中心：www.health.gov/nhic

紐約聯繫處（長期護理服務與支援；提供家庭訪問服務）------------ 1-800-342-9871
布朗克斯（SHOPP 社區）：1-347-862-5200
布魯克林 (JASA)：1-718-671-6200
曼哈頓（紐約老年人基金會）：1-212-962-2720
皇后區（自助社區服務）：1-718-559-4400
史坦登島 (CASC)：1-718-489-3954

紐約法律協助團體 (NYLAG) 的 Evelyn Frank 法律資源計畫 ------------ 1-212-613-7310
EFLRP@NYLAG.org。

紐約州衛生署（健保市場計畫聯絡人）------------ 1-855-355-5777
https://nystateofhealth.ny.gov

紐約市衛生局------------ 311
www.nyc.gov/health

紐約州長期護理調解員計畫 ------------ 1-855-582-6769
https://ltcombudsman.ny.gov/

紐約州衛生署——醫療補助及保險市場交易——HMO 投訴專線------------ 1-800-206-8125

紐約州金融服務廳 ------------ 1-800-342-3736
www.dfs.ny.gov

紐約州醫療補助專線------------ 1-800-541-2831

紐約州老人局老人服務專線 ------------ 1-800-342-9871
www.aging.ny.gov

紐約州犯罪受害者服務辦公室 ------------ 1-800-247-8035
https://ovs.ny.gov/help-crime-victims

紐約州衛生署專業醫療行為辦公室（醫師品質管理投訴）------------ 1-800-663-6114

紐約大學牙醫診所 ------------ 1-212-998-9800
www.nyu.edu/dental

鐵路職工退休管理委員會 ------------ 1-877-772-5772
www.rrb.gov

SMP（原老人醫療保險巡邏計畫）用以報告紐約州醫療補助的詐騙和濫用 1-800-333-4374

社會安全局------------ 1-800-772-1213
www.socialsecurity.gov 聽障專線 1-800-325-0778

美國退伍軍人事務部------------ 1-800-827-1000
www.va.gov

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