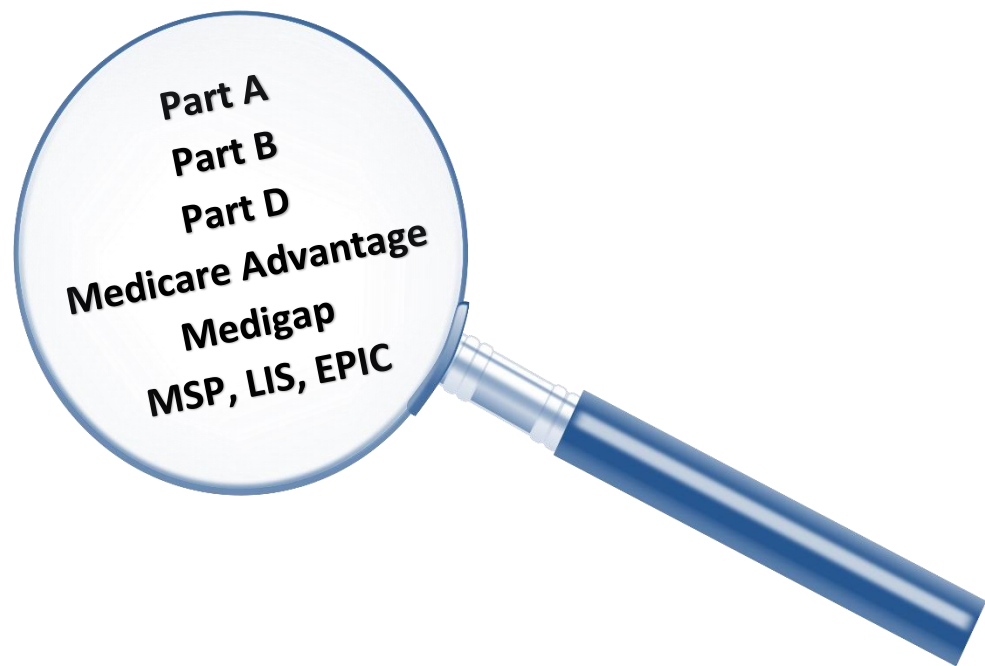


A Closer Look at Medicare and Related Benefits for New Yorkers

2021



NEW YORK
STATE OF
OPPORTUNITY™

HIICAP

Health Insurance Information,
Counseling and Assistance
Program

Medicare questions? Call Aging Connect at 212-AGING-NYC.

Updated January 2021



HIICAP

Health Insurance Information,
Counseling and Assistance
Program

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-AGING-NYC (212-244-6469) and ask for HIICAP to speak with one of our trained counselors.

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

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

www.nyc.gov/aging

<https://aging.ny.gov/programs/medicare-and-health-insurance>

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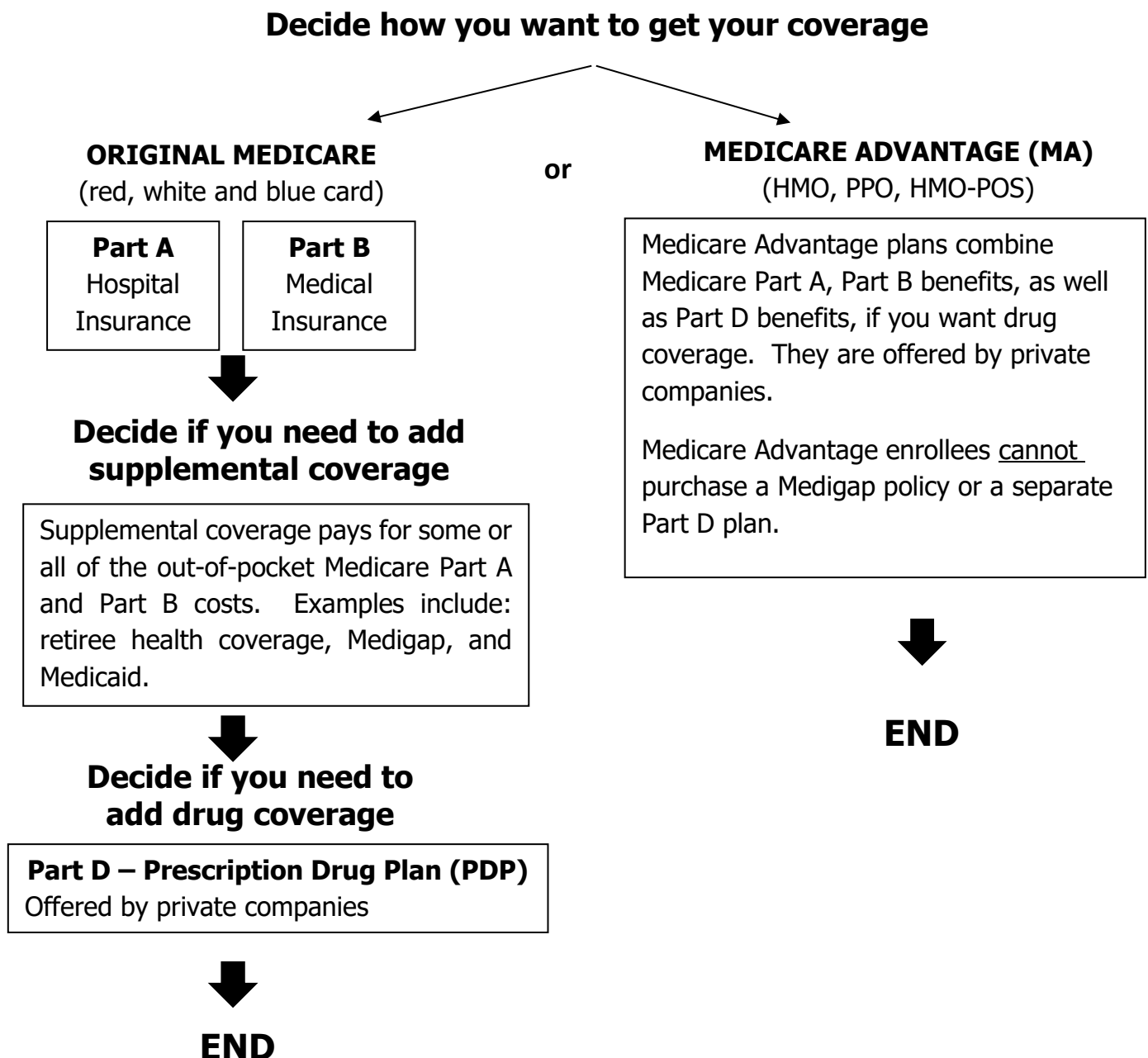
Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

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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.



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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.

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



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Special Enrollment Period (SEP)

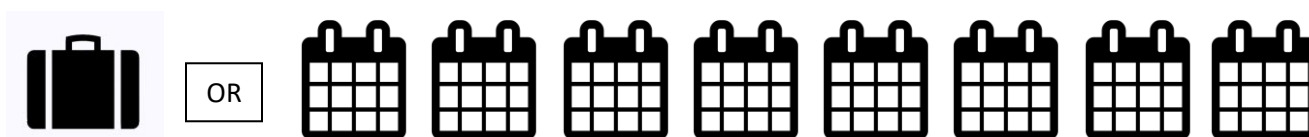
If you or your spouse are **actively employed** and you have **health insurance** through that current/active employer or union, you may not need to enroll in Medicare Part B when you first become eligible; contact the employer or union as to whether they require enrollment in Part B.

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>. This form is submitted along with CMS-40B, Application for Enrollment in Medicare - Part B, to Social Security, with the desired start month and year for Part B coverage to start.

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

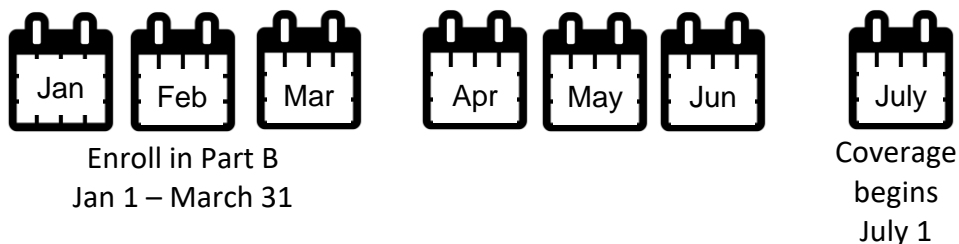
General Enrollment Period (GEP)

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.

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When Is The General Enrollment Period?



Enrolling in Medicare Part A is more flexible than 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.

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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 inpatient in a hospital (not counting the day of discharge). Medicare will help pay for up to 100 days in a SNF in a benefit period.

Observation Status

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.

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 (2021)

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 \$474 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium will be \$259 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: \$1,484 per benefit period (covers days 1-60)

Additional cost sharing:

- \$371 per day for days 61-90
- \$742 per Lifetime Reserve Day (60 days)

Skilled Nursing Facility Costs:

Days 1-20: Medicare pays 100%

Days 21-100: \$185.50 per day

If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day. **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 | • Injectibles |
| • Outpatient hospital services | • X-rays |
| • Mental health care | • Lab tests (covered at 100%) |
| • Blood, after the first 3 pints | • Durable medical equipment |
| • Ambulance transportation | • Medical supplies (including test strips and lancets used with blood glucose monitors) |
| • Physical, speech & occupational therapy | • Home care (see page 8) |
| • Preventive & screening tests | |
| • Flu, COVID-19, pneumonia & hepatitis B vaccines | |

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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 (2021)

Standard monthly **premium** is \$148.50. About 4% of Medicare beneficiaries pay less than this amount.

- Higher income individuals (over \$88,000 for individuals; \$176,000 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 2021, SSA looks at your 2019 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 66 for more information for the current IRMAA amounts.

Annual Deductible: \$203

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.

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- 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.

Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

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.

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

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

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

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

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

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

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

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature: 	J. Date:
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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)	<p>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.</p> <p>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.</p>
Colorectal cancer screening	<ul style="list-style-type: none"> • 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. • Multi-target stool DNA tests: covered once every 3 years for people with Medicare who are between 50 and 85 years old; show no signs or symptoms of colorectal disease; and are at average risk of developing colorectal cancer.
Depression screening	Medicare covers depression screenings by your primary care doctor once every 12 months.
Diabetes screening	Medicare covers up to 2 diabetes screenings per year for people at risk for diabetes.

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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.
Nutrition therapy services	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	<ul style="list-style-type: none"> • 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.
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	<ul style="list-style-type: none"> • NEW - COVID-19 • 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.

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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.

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.

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>.

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.

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

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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.

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 (\$371 per day in 2021) for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for the Part A copayment amount (\$742 per day in 2021) 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 (\$203 in 2021).

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

- Coverage for the Medicare Part A inpatient hospital deductible (\$1,484 per benefit period in 2021).

PLAN C¹ includes the **basic benefit, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care copayment amount (\$185.50 per day for days 21 through 100 per benefit period in 2021).
- Coverage of the Medicare Part B deductible (\$203 per calendar year in 2021).
- 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.

PLAN F¹ 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.

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.

- Coverage for 100% of Medicare Part B excess charges, also known as limiting charge².
- 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 \$2,370 deductible in 2021 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 charge¹.
- 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 \$2,370 deductible in 2021 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 K³ 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.
- 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.

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.

- Coverage for 50% of the skilled nursing facility care daily copayment amount.
- Annual out of pocket limit of \$6,220 in 2021.

PLAN L³ 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 \$3,110 in 2021.

Plan M³ 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 N³ 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.

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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 \$6,220	Out of Pocket limit \$3,110		

*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.

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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	<u>Aetna</u> 800-345-6022	<u>Bankers Conesco</u> 800-845-5512	<u>Emblem (formerly GHI)</u> 800-444-2333	<u>Empire Blue Cross Blue Shield</u> 855-306-9355	<u>Globe Life Insurance*</u> 800-331-2512	<u>Humana</u> 800-486-2620	<u>Mutual of Omaha</u> 800-228-9999	<u>TransAmerica Financial</u> 800-752-9797	<u>United Health (AARP)</u> Must be an AARP member to enroll (age 50+) 800-523-5800
A	\$318.21	\$367.70	\$194.87	\$179	\$240/268	\$321.19	\$333.49	\$195	\$178.50
B	\$362.44	\$480.69	\$253.28	\$241.11	\$330/370	\$362.61	\$512.25	\$257	\$256.50
C**			\$300.87		\$397/444	\$439.46	\$512.82	\$304	\$320
D					\$391/438		\$503.90	\$280	
F**	\$422.90	\$648.95	\$530.29	\$307.40	\$374/419	\$448.38	\$516.15	\$306	\$308.25
F+**		\$75.69	\$74		\$69/77	\$93.09			
G	\$406.26	\$597.30	\$302	\$270.14	\$348/390	\$400.38	\$478.04	\$281	\$270
G+		\$75.69	\$67.69		\$69/77	\$92.97			
K		\$99.74			\$137/154	\$209.34		\$140	\$83.50
L		\$286.73			\$206/231	\$298.98		\$208	\$173.25
M		\$397.13					\$526.10	\$256	
N		\$390.82	\$220	\$192.22	\$259/290	\$284.05		\$241	\$200.25

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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 and live in the plan's service area. A Medicare Advantage plan cannot turn away an applicant because of health problems (or impose a waiting period for pre-existing conditions).

Joining a Medicare Advantage plan is a choice. 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.

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

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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).

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

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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.

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.

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 2021, maximum out-of-pocket costs (MOOP) cannot exceed \$7,550 in-network for HMO plans and \$11,300 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.

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.

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 \$88,000 for an individual or \$176,000 for a couple) will pay a surcharge for Part D in addition to their plan premium. The surcharge ranges from \$12.30 to \$77.10 per month in 2021, and is paid in the same way as the Part B premium, typically as a deduction from one's Social Security check (see page 66 for rate chart).

Although Part D plans' benefit designs vary, they each include the following minimum levels of coverage in 2021:

- **Deductible** (up to \$445). This is the amount that you have to pay out-of-pocket before your plan helps pay for the cost of your drugs. Some plans have a lower deductible or no deductible.

- **Initial Coverage Level.** You pay a fixed copay of up to 25% of drug costs up to \$4,130 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 \$4,130 in total drug costs, you pay 25% of brand name and generic drug cost (plus a nominal pharmacy dispensing fee), until **you** have incurred \$6,550 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 \$6,550 in out-of-pocket expenses). The beneficiary is responsible for the greater of five percent (5%) of drug costs or a copay of \$3.70 for generic medications and \$9.20 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.

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" (\$33.06 in 2021) 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. This is vital, since enrollment in a Part D plan may compromise **all** health benefits through that employer, not just prescription drug coverage.

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. You may face a late enrollment penalty if you do not enroll when you are first eligible.

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.

Follow the Planfinder prompts so all of the medications you are currently taking or expect

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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, 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.

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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 \$42.27 in 2021).
- 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 \$4.00 for brand name prescriptions. All others with full Extra Help will have co-pays limited to \$3.70 for generic and \$9.20 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 \$92.
- Reduced co-pays – pay the lower of 15% of drug costs or the plan's cost-sharing.

Extra Help Income and Asset Limits (2021)				
	Individual		Married Couple	
	Monthly Income	Assets	Monthly Income	Assets
Full Extra Help	\$1,469	\$9,470	\$1,980	\$14,960
Partial Extra Help	\$1,630	\$14,790	\$2,198	\$29,520

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

Individuals with Extra Help will not be subject to a late enrollment penalty in Part D. Additionally, those with Extra Help may change their Part D plan at additional times during the year. See page 33 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.

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 \$42.27 per month in 2021. 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

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couple with an income of \$29,000, each person must meet an annual deductible of \$700. There is no fee to join the deductible plan.

EPIC pays the Part D monthly premium (up to \$42.27 per month in 2021) 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 (\$507.24 in 2021).

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.

You can enroll in EPIC at any time of the year. 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 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 (RAFI) 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.

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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 – 2021				
	Single		Married Couple	
	Income	Resources	Income	Resources
QMB: 100% FPL	\$1,093	No Limit	\$1,472	No Limit
SLMB: 120% FPL	\$1,308	No Limit	\$1,762	No Limit
QI: 135% FPL	\$1,469	No Limit	\$1,980	No Limit

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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-AGING-NYC (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.

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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 Fraud?

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 Abuse?

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.

Medicare Do's and Don'ts

- 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.

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/scams.

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

Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

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 53 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 \$884 for single individuals/\$1,300 for married couples, and an **asset** limit of \$15,900 (plus \$1,500 in a burial fund) for single individuals/ \$23,400 (plus \$3,000 in burial funds) for married couples in 2021.

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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, with the exception of those applying for community-based long-term care services**. For Medicaid covered long term care services, NYS's recent budget imposes a 30-month lookback period to be phased in over time, beginning with transfers made on or after October 1, 2020. Initially set to begin on January 1, 2021, the implementation of the lookback has been delayed until April 1, 2021 due to the COVID-19 Public Health Emergency. The lookback will apply to new applications for home care services; those already enrolled will not have any lookback on asset transfers.

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 at https://www.health.ny.gov/health_care/medicaid/alternative_forms.htm.

Where do I submit the application?

You have a choice of where and how to submit your Medicaid application:

- Contact a facilitated enroller near you for assistance. 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 65 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.

Eliminating the “Spenddown” for Medicaid Applicants

Disabled 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).

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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/\$4.00 for brand name prescriptions in 2021. Those with incomes over 100% FPL will have co-pays of \$3.70 for generic/\$9.20 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.

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 your current Medicare and Medicaid provider arrangements. MLTC enrollees will continue to use their current plan (i.e. your Medicare card, your Medicaid card, or

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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.

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 CFEED 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.wnyc.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.

Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

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?

Beginning December 1, 2020, new enrollment into an MLTC plan will have a lock-in period (note: this rule does not apply to MAPlus or PACE plan enrollment). The enrollee has a grace period during the first 90 days in a new plan. During the grace period, one can transfer to a new MLTC plan. After 90 days, one is locked into the MLTC plan for 9 months; one can only change plans if you have "good cause." After the 9-month lock-in period, you can change plans at any time. New York Medicaid Choice (Maximus) handles enrollment for Medicaid managed long-term care and can be reached at 1-888-401-6582.

How can I get help with managed long term care plans?

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

MEDICAID FOR INSTITUTIONAL CARE: Income and asset guidelines are stringent for institutional Medicaid. Generally speaking, 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 2021, the total amount of money transferred will be divided by \$13,037 to determine the number of months of the penalty period. For example, if an applicant was found to have transferred \$130,370 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 2021 under Medicaid, the community spouse may retain a minimum of \$74,820 and a maximum of \$130,380 in assets and \$3,259.50 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.

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.
- 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 \$1,481 monthly for individuals/\$2,003 for couples in 2021, 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.

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 \$1,481-\$2,147 for individuals/\$2,003-\$2,903 for a household of two in 2021. 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 \$1,481-\$1,610 for individuals/\$2,003-\$2,177 for a household of two in 2021) 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 \$1,610-\$2,147 for individuals/\$2,177-\$2,903 for a household of two in 2021) pay \$20/month for coverage, \$0 deductible, and low copays, with an annual maximum out-of-pocket cost of \$2,000.

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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.

QUALIFIED HEALTH PLANS

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

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.

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.

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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 of 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.

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 of \$50 per person or \$100 per family per calendar year. In addition, there is a 25% co-insurance. CHAMPVA 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.

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/>.

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

Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

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.

MEDICARE 2021

Part A: Hospital Insurance

Deductible	\$1,484 per benefit period
Co-Payment	\$371 per day for days 61-90 of each benefit period
	\$742 per day for each "lifetime reserve day"
Skilled Nursing Facility Co-Pay	\$185.50 per day for days 21-100 of each benefit period

Part B: Medical Insurance

Monthly Premium	Most Medicare beneficiaries pay the standard premium of \$148.50, except for: <ul style="list-style-type: none"> Those whose Social Security Cost of Living Adjustment (COLA) didn't increase enough to raise their Part B premiums to the \$148.50 level. Higher income (over \$88,000 single/176,000 married) beneficiaries will pay higher amounts.
Annual Deductible	\$203
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 2021, if you have less than 30 quarters of Social Security coverage, your Part A premium is \$471 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium is \$259 per month.

Medicare Savings Program - 2021

	Monthly	
	Individual	Couple
QMB - Qualified Medicare Beneficiary NY State pays premiums, deductibles and co- insurance for those who are automatically eligible for Part A.	\$1,093	\$1,472
SLMB - Specified Low-Income Medicare Beneficiary Levels State pays Medicare Part B premium only.	\$1,308	\$1,762
QI - Qualifying Individuals State pays Medicare Part B premium only.	\$1,469	\$1,980

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

Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

MEDICAID 2021

Standard Medicaid

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

	<u>Monthly Income</u>	<u>Assets</u>
Individual	\$884	\$15,900
Couple	\$1,300	\$23,400

*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; \$130,380 maximum **Income:** \$3,259.50 monthly

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

Medicaid Offices in New York City

Medicaid applicants can call the Medicaid Helpline at 1-888-692-6116 to find the nearest Medicaid office, office hours and directions. New York City residents can apply at any office in the five boroughs. Office hours are Monday-Friday, from 9 am – 5 pm, unless otherwise noted.

NOTE: Due to the COVID-19 Public Health Emergency, some Medicaid offices are closed to the public. Only the offices noted with an asterisk (*) are open at the time of printing.

Citywide Medicaid Office:

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

Manhattan

- Chinatown Medicaid Office: 115 Chrystie Street, 5 floor. (212) 334-6114
- *Manhattanville Medicaid Office: 520-530 West 135th Street, 1st floor. (212) 939-0207 ext. 0208

Bronx

- Fordham: 2541-2549 Bainbridge Ave. (929) 252-3230
- Morrisania Diagnostic & Treatment Center: 1225 Gerard Avenue, Basement. (718) 960-2799
- *Rider Medicaid Office: 305 Rider Avenue, 4th Floor. (718) 585-7872 OPEN 8:30 am – 5 pm

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 ext. 2301
- *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

Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

Medicare Part B and Part D Income-Related Monthly Adjustment Amount (IRMAA) for Higher Income Medicare Beneficiaries in 2021

2019 Modified Adjusted Gross Income (MAGI)	Part B Monthly Premium	Part D (Prescription Drug) Monthly Premium
Individuals with a MAGI of \$88,000 or less / Married couples with a MAGI of \$176,000 or less	2021 Standard Premium = \$148.50	Your Plan Premium
Individuals with a MAGI \$88,000-\$111,000/ Married couples with a MAGI \$176,000-\$220,000	\$207.90	Your Plan Premium + \$12.30
Individuals with a MAGI \$111,000-\$138,000/ Married couples with a MAGI \$220,000-\$276,000	\$297.00	Your Plan Premium + \$31.80
Individuals with a MAGI \$138,000-\$165,000/ Married couples with a MAGI \$276,000-\$330,000	\$386.10	Your Plan Premium + \$51.20
Individuals with a MAGI \$165,000-\$500,000/ Married couples with a MAGI \$330,000-\$750,00	\$475.20	Your Plan Premium + \$70.70
Individuals with a MAGI greater than \$500,000 / Married couples with a MAGI greater than \$750,000	\$504.90	Your Plan Premium + \$77.10
Married filing separately with a MAGI less than \$88,000	\$148.50	Your plan premium
Married filing separately with a MAGI \$88,000-\$412,000	\$475.20	Your Plan Premium + \$70.70
Married filing separately with a MAGI \$412,000 and greater	\$504.90	Your Plan Premium \$77.10

- Modified Adjusted Gross Income is equal to gross income + tax exempt interest income
- 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.

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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 by 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.

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.pharmacy

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

RESOURCES

HIICAP Helpline – Call NYC Department for the Aging’s Aging Connect and ask for HIICAP	1-212-AGING-NYC (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-AGING-NYC (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.acl.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

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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
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	
United States Department of Veterans Affairs.....	TTY 1-800-325-0778
www.va.gov	
1-800-827-1000	

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NOTES

Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

Bill de Blasio

Mayor

City of New York



Lorraine Cortés- Vázquez

Commissioner

NYC Department for the Aging