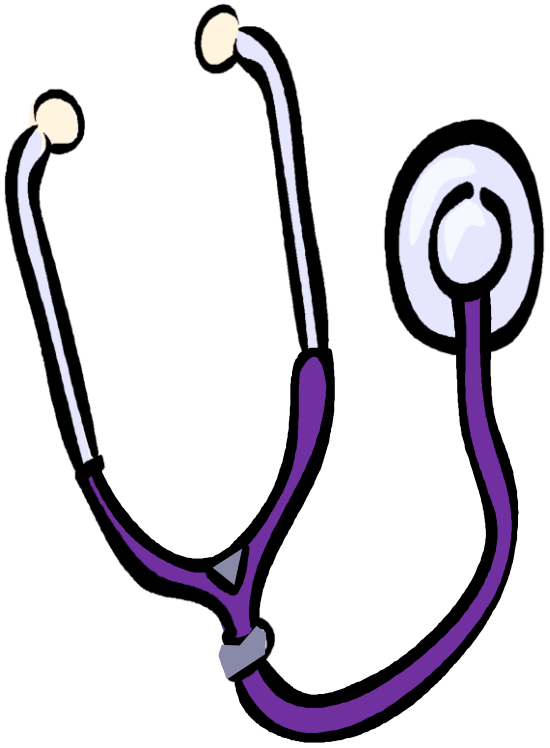
A Complete Guide to

Health Insurance Coverage for

Older New Yorkers

2018



HIICAP
NYC DEPARTMENT FOR THE AGING
Health Insurance Information
Counseling & Assistance Program

Updated January 2018

Bill de Blasio

Mayor

City of New York

Donna M. Corrado, PhD

Commissioner

NYC Department for the Aging

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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, Medicaid, and Long-Term Care Insurance. 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 311 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 necessarily constitute endorsement of these programs on the part of the New York City Department for the Aging.

Dial 311 for information regarding this and other City services.

www.nyc.gov/aging
www.aging.ny.gov/healthbenefits

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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. It has four components:

- Hospital Insurance (Part A).
- Medical Insurance (Part B).
- Medicare Advantage plans (Part C - HMO, PPO, Special Needs Plans). Medicare Advantage plans provide hospital and medical coverage. If someone joins a Medicare Advantage plan, they will have coverage through that private plan, not through "original Medicare."
- Prescription Drug Coverage (Part D). Medicare Advantage enrollees who want drug coverage must get that coverage through their plan. Enrollees in "original Medicare" who want drug coverage sign up for a stand-alone Part D plan.

Who is Eligible for Medicare?

You are eligible for Medicare if you are 65 years old or older, and a citizen or permanent resident of the United States for at least five consecutive years. People under age 65 may qualify for coverage after receiving Social Security Disability Insurance (SSDI) for 24 months; people with Amyotrophic Lateral Sclerosis (ALS) qualify the first month they receive SSDI. People 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. If you or your spouse (including same-sex spouse) are insured through Social Security (by having earned 40 quarters of coverage), you are eligible for premium-free Part A at age 65. Without 40 quarters of coverage, one may still get Medicare by paying a premium for Part A at age 65. 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?

Automatic Enrollment: 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. If you receive Social Security Disability benefits, you will automatically get a Medicare card in the mail after you have received Social Security Disability benefits for 24 consecutive months. If you wish to decline Medicare benefits, follow the instructions mailed with the Medicare card.

If you are not receiving Social Security benefits as you approach age 65, and you want your Medicare benefits at age 65, you must 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.

Applying for Medicare Part A: 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. Those

who need to pay a premium for Part A (don't have 40 quarters of coverage through Social Security) can only enroll during their Initial Enrollment Period, and thereafter only from January 1-March 31, with coverage effective July 1. These individuals may incur a 10% Late Enrollment Penalty.

Applying for Medicare Part B: If you are not receiving Social Security when you turn 65, you have a seven-month Initial Enrollment Period (IEP) in which to enroll in Medicare. You can enroll by contacting the Social Security Administration (SSA) three months before you turn 65, the month in which you turn 65, and the three months that follow. 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.

If you do not enroll during this seven-month period and do not have health insurance through a current and active employer (yours or your spouse's) you will have to wait to enroll during the General Enrollment Period which is January 1 to March 31 of each year, but Part B coverage will not start until July 1. If you do not enroll during the initial enrollment period and do not have other coverage through an active employer of you or your spouse, you may face a higher premium as a penalty for late enrollment. The penalty for late enrollment is 10% for every 12 months of non-enrollment in Part B. NOTE: COBRA coverage is NOT coverage through an active employer, thus COBRA does not qualify you for a special enrollment period.

Actively Employed and Medicare Eligible: If you or your spouse are actively employed and have health insurance through that 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. You may wish to enroll in Part A regardless because there is no premium for this coverage, though this is prohibited if you are contributing to a Health Savings Account (HSA). Refer to the section on Medicare as Secondary Payer (see page 12) for more information.

NEW

Medicare Card Replacement: The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires that Medicare no longer use Social Security numbers on their cards in order to prevent identity theft. Between April 2018-April 2019, Medicare will be sending new Medicare beneficiaries their cards with a randomly assigned identifier, not related to any personal information. All existing beneficiaries will receive replacement cards in the mail. The new Medicare beneficiary identifier (MBI) will have 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. Medicare beneficiaries will receive the new card automatically, but should contact Social Security to confirm their mailing address.

TIP: To locate providers in the Medicare program, visit www.medicare.gov or call 1-800-MEDICARE.

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.

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 and 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 after day 90 of each 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 more 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. 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.

Most people are eligible for premium-free Part A because they or their spouse have at least 40 quarters of coverage with Social Security. Those who do not have 40 quarters of coverage with Social Security can pay a monthly premium for Part A coverage. In 2018, if you have less than 30 quarters of Social Security coverage, your Part A premium will be $422 a month**.** If you have 30 to 39 quarters of Social Security coverage, your Part A premium will be $232 per month. For low-income beneficiaries who qualify for the QMB Medicare Savings Program (see page 36), QMB may also be able to pay the Part A premium for those who do not qualify for premium-free Part A.

Part A Cost Sharing in 2018:
- Deductible: $1,340 per benefit period
- Days 61-90 of an inpatient stay: $335 per day
- Lifetime Reserve Days: $670 per day

Skilled Nursing Facility Care: If after being discharged after a three-day minimum stay as an inpatient in a hospital (not counting the day of discharge), you need to go to a skilled nursing facility (SNF), Medicare will help pay for your care for up to 100 days in a benefit period. (Days under "observation" status in a hospital are covered under Medicare Part B, and are not counted towards the three-day qualifying minimum stay for SNF coverage.) Medicare Part A pays the full cost of covered services for the first 20 days. All covered services for the next 80 days are

paid for by Medicare except for a daily co- payment amount of $167.50 in 2018. 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.**

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 home health agency. A prior stay in the hospital is not required to qualify for home health care, and you do not have to pay a deductible for home health services. Medicare Part A pays the entire bill for covered services for as long as they are medically reasonable and necessary. 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 care, you may also qualify for other services, such as a home health aide and medical social workers.

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 42 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. The care can be at home or as an inpatient, and includes many services usually not covered by Medicare, such as homemaker services, counseling, and certain prescription drugs.

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 also helps pay for:

- Outpatient hospital services
- Outpatient mental health care
- Blood, after the first 3 pints
- Ambulance transportation
- Physical, speech & occupational therapy
- Preventive & Screening tests
- Flu, pneumonia & hepatitis B vaccines
- Injectibles
- Artificial prostheses
- X-rays & lab tests
- Durable medical equipment
- Medical supplies

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 premium on a quarterly basis.

In 2018 the standard monthly **premium** is $134. About 28% of Medicare beneficiaries will be paying less than this amount. This has to do with Social Security's Cost of Living Adjustment (COLA) increases for prior years; the COLA increases did not keep pace with the Part B Premium increases. Medicare beneficiaries were "held harmless" from a premium increase that would have resulted in a reduction in their net Social Security check.

The 2018 COLA will be 2%. While beneficiaries' gross Social Security benefits will increase 2%, the increase will go towards raising their Part B premium to the $134 amount.

Higher income individuals (over $85,000 for individuals; $170,000 for married couples) will be responsible for higher premiums, known as the Income Related Medicare Adjustment Amount (IRMAA). Social Security determines whether each person is subject to IRMAA by looking at tax filings for 2-years prior; IRMAA is re-evaluated each year. For example, in 2018, SSA looks at your 2016 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.pdf). See page 63 for more information for the current IRMAA amounts.

You are responsible for paying the annual Part B **deductible**, $183 in 2018. After meeting the deductible, Medicare pays for 80% of Medicare-approved charges. You are responsible for paying the other 20%, referred to as the Medicare **coinsurance**.

Medicare covers **physical and speech therapy** services up to $2,010 per year and **occupational services** up to $2,010 per year in 2018. The cap includes all therapy done in the office, home (if not receiving Medicare-covered home health care services), and care in the outpatient department of a hospital. There are certain exceptions which allow the cap to be extended, such as for more complicated medical conditions. You can check with your physical therapist to see if you qualify for an exception.

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 15 for information on Medigap policies.

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. Below are descriptions of each of these scenarios.

- 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 the amount Medicare approves 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 Limiting Charge that applies for office visits and home visits is 15%. For most other services provided by physicians in New York State, the Limiting Charge is 5%.
    - 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 can "**Opt Out**" of the Medicare program. Medicare providers have the right to officially "opt out" of Medicare for a two-year period and enter into a private written contract with any Medicare patient who seeks their treatment. The doctor 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 patient. 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. "Opting Out" is different from providers who do not accept Medicare Assignment, where the set fees and reimbursements are still controlled by Medicare.

Advance Beneficiary Notice of Non-Coverage

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. Providers must use an ABN for physical, speech and occupational therapy services. Without a signed ABN, the beneficiary is not responsible for charges in excess of the cap for these services (see following page for a sample ABN). The beneficiary retains appeal rights, even with a signed ABN.

Medicare Summary Notice

For assigned claims, 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. For unassigned claims, a MSN will be mailed as the claims are processed, along with a check to the beneficiary, if the beneficiary has already paid for the service. Beneficiaries will be able to utilize the MSN for reimbursement from a Medigap policy. The MSN also contains information on how you can appeal Medicare claim denials. Beneficiaries can also access their MSNs electronically at 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.

A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

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

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

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

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.

Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the **D.** _____ listed above.

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

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

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

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

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

H. Additional Information:

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

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

I. Signature:	J. Date:

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:

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.
Behavioral Therapy for Cardiovascular Disease (CVD)	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.
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.
Cardiovascular Screening	Medicare covers cardiovascular screenings that check cholesterol and other blood fat (lipid) levels once every 5 years.
Colorectal Cancer Screening	Fecal Occult Blood Test: covered once every 12 months. Flexible Sigmoidoscopy: covered once every 48 months. Colonoscopy: covered once every 24 months if you are at higher risk for colon cancer. If you are not at higher risk it is covered once every 10 years but not within 48 months of a screening flexible sigmoidoscopy. Barium Enema: this can be substituted for a flexible sigmoidoscopy or colonoscopy; you pay 20% of the Medicare-approved amount. Cologuard™ test: covered **once every 3 years** for people with Medicare who are between 50 and 85 years old; show no signs or symptoms of colorectal disease; and are at average risk of developing colorectal cancer.
Depression Screening	Medicare covers depression screenings by your primary care doctor once every 12 months.
Diabetes Services	Diabetes screenings for those at higher risk covered at 100%. Coverage for glucose monitors, lancets, test strips and diabetes self-management training for both insulin and non-insulin dependent of those diagnosed with diabetes. You pay 20% of the Medicare-approved amount after the Part B deductible.
Glaucoma Screening	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 C Screening	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 Test	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.

Mammogram Screening	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.
Medical Nutrition Therapy	Medicare covers 3 hours of one-on-one counseling services the first year, and 2 hours each year after that for beneficiaries with diabetes or kidney disease.
Obesity Screening and Counseling	If you have a body mass index of 30 or more, Medicare covers a dietary assessment as well as intensive behavioral counseling and behavioral therapy.
Pap Test and Pelvic Exam	A pap test, pelvic exam and clinical breast exam are covered every 24 months, or once every 12 months for women at higher risk for cervical or vaginal cancer. All women with Medicare are covered.
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 Tests	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 High-Intensity Behavioral Counseling (HIBC) to prevent STIs	Medicare covers screening for Chlamydia, gonorrhea, syphilis and hepatitis B, as well as high intensity behavioral counseling (HIBC) to prevent STIs. The screening is for up to two individual 20 to 30 minute, face to face counseling sessions annually for those at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting.
Smoking Cessation Counseling	Counseling to stop smoking. Medicare will cover up to 8 face-to-face visits during a 12-month period for beneficiaries who use tobacco.
Vaccinations/Shots	Flu: Covered once per flu season. Pneumonia: Usually only needed once in a lifetime. A different, second shot, is covered 12 months after you get the first shot. Hepatitis B: Covered if at high or intermediate risk.

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 <u>current</u> 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.

<u>Liability insurance and Medicare</u>: 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.

Working after age 65-Employer Group Health Plans (EGHP) and Medicare: When a Medicare beneficiary over age 65 continues to work, their employer or their spouse's employer must provide the same coverage for all employees and families, regardless of age. 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 open to those who are working who have employer coverage. Look on the Medicare website at www.medicare.gov or call 1-800-MEDICARE for more information. 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. Enrollment in Medicare Part B should be done within 8 months of the end of active employment, not at the end of health care coverage, in order to avoid a possible gap in coverage and a late enrollment penalty.

Retiree health coverage: Generally speaking, in cases where one has both Medicare and retiree health insurance, Medicare is primary and retiree coverage is secondary. For some, retiree benefits work more like a supplement to Original Medicare, while for others it acts more like a Medicare Advantage plan.

Federal Employee Health Benefits (FEHB): Unlike most retiree plans that require enrollment in Medicare, the Federal Employees Health Benefits (FEHB) program will 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 enroll in Part B also. 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.

Disability and Medicare: If a person becomes disabled and is unable to work, an EGHP generally covers the costs. If the company employs 100 or more individuals, the EGHP is primary and Medicare is secondary. If there are fewer than 100 employees, Medicare is primary and the EGHP is secondary. Disability, as determined by Social Security, will entitle an individual to Medicare coverage after the 24th month of disability payments without regard to age.

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 employer group health plan, it 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. Pre-existing conditions can be paid for by Medicare if Worker's Compensation does not cover these conditions. 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.

MEDICARE SUPPLEMENT INSURANCE (Medigap)

What is a Medigap policy?
Medicare Supplement Insurance (Medigap) is specifically designed to fill the gaps in 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.

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 in the United States, designated "A" through "N." Each of the policies covers the basic benefit package (which cannot be changed by adding or subtracting the provisions), 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. Some of the older policies may provide better coverage, especially for extended skilled nursing care. Effective June 1, 2010, plans E, H, I and J are no longer offered to new enrollees. Individuals with Medigap plans E, H, I and J can maintain their existing coverage, but may wish to compare benefits with the premium cost to determine whether their plan remains cost effective.

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 plan's set of benefits is right for you, you can compare the premium, service and reputation of the insurance companies. Most Medigap insurers have linked their computers with the computers at Medicare, so that your claims can be processed without

additional paperwork ("electronic crossover"). In addition, 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 F, 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 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 C 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 21 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 health problem. 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 after turning 65 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 http://dfs.ny.gov/consumer/caremain.htm#sub_gen.

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 for your health benefits. 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.

How can I get help in choosing a Medigap policy?
Trained HIICAP counselors have current information on Medigap policies. They will not make

the choice for you, but they will give you the specific information you need to make your decision.

How does Medicare Part D interact with Medigap policies?
No new Medigap policies offer drug coverage. There is no interaction between newer Medigap policies and Part D.

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 ($335 per day in 2018) for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for the Part A copayment amount ($670 per day in 2018) 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 ($183 in 2018).

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

- Coverage for the Medicare Part A inpatient hospital deductible ($1,340 per benefit period in 2018).

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

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care copayment amount ($167.50 per day for days 21 through 100 per benefit period in 2018).
- Coverage of the Medicare Part B deductible ($183 per calendar year in 2018).
- 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 F includes the **basic benefit, plus**

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

PLAN F+ (high deductible)

- Same benefits as the Standard Plan F, but you will have to pay a $2,240 deductible in 2018 before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums.

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

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

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

PLAN K[2] 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.
- Coverage for 50% of the skilled nursing facility care daily copayment amount.
- Annual out of pocket limit of $5,240 in 2018.

[1] 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).

[2] 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.

PLAN L[3] includes the **basic benefit, plus**

- Coverage for 75% of Medicare Part A inpatient hospital deductible.
- Coverage for 75% of Part B coinsurance after you meet the yearly deductible for Medicare Part B, but 100% coinsurance for Part B preventive services.
- Coverage for 100% of the Part A copayment amount for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A copayment amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for 75% hospice cost-sharing.
- Coverage for 75% of Medicare-eligible expenses for the first 3 pints of blood.
- Coverage for 75% of the skilled nursing facility care daily coinsurance amount.
- Annual out of pocket limit of $2,620 in 2018.

Plan M[3] includes the **basic benefit, plus**

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

Plan N[3] includes the **basic benefit, plus**

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

Always consider inquiring about a particular membership or group insurance rate from a current or previous employer that might be less expensive than purchasing an individual plan on your own.

[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.

BENEFITS INCLUDED IN THE TEN STANDARD MEDICARE SUPPLEMENT PLANS

Basic Benefit: Included in all plans

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

A	B	C	D	F*	G	K	L	M	N
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit**	Basic Benefit**	Basic Benefit	Basic Benefit**
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance (50%)	Skilled Nursing Coinsurance (75%)	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible (50%)	Part A Deductible (75%)	Part A Deductible (50%)	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess	Part B Excess				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out of Pocket limit $5,240	Out of Pocket limit $2,620		

*Plan F is also offered with a high deductible option.

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

MEDICARE SUPPLEMENT INSURANCE POLICIES

Prepared by the NYC Department for the Aging's Health Insurance Information Counseling Assistance Program (HIICAP) 1-212-602-4180. 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 NY State Department of Insurance website at http://www.dfs.ny.gov/consumer/medplan/medsup18.pdf.

*Globe Life Insurance (formerly First United American) premiums differ by zip code.

Go to: https://myportal.dfs.ny.gov/web/guest-applications/medicare-monthly- premiums for the rate in your zip code.

**Empire Blue Cross Blue Shield, Sterling Life and American Progressive no longer sell Medigap policies to new subscribers. They will continue to renew Medigap policies for current policyholders indefinitely, so long as they continue to pay their premiums.

PLAN	Aetna 800-345-6022	Bankers Conseco 800-845-5512	Globe Life Insurance* 800-331-2512	GHI 800-444-2333	Humana 800-486-2620	Mutual of Omaha 800-228-9999	United Health (AARP) Must be an AARP member to enroll (age 50+) 800-523-5800
A	$318.21	$335.51	$207/232	$169.45	$260.19	$278.72	$164.25
B	$362.44	$438.59	$284/319	$226.14	$327.57	$427.95	$238
C			$343/384	$300.87	$396.97	$481.19	$293
D			$338/379			$451.22	
F	$422.90	$592.09	$324/363	$331.43	$405.01	$484.32	$294.50
F+		$75.69	$64/71		$93.09		
G		$544.97	$301/338		$361.68	$428.09	$264.50
K		$99.74	$127/142		$189.20		$76.50
L		$261.66	$179/200		$270.13		$159.50
M		$362.37				$439.52	
N		$308.70	$224/251		$256.65		$187.25

CALL 311 AND ASK FOR HIICAP

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

Medicare Advantage plans provide beneficiaries in New York City with alternatives to "original" Medicare. Medicare Advantage plans are offered by private companies to offer Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPO), HMOs with Point-of-Service option (HMO-POS), and Special Needs Plans (SNP) to Medicare beneficiaries. These companies receive a fixed monthly payment from the federal government to provide Medicare benefits to enrollees.

Every Medicare Advantage plan must provide its members with all of the same medically-necessary services that "original" Medicare covers, and may include additional services, such as a prescription drug benefit, vision, dental and hearing services. 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.

HMO, PPO, HMO-POS, and SNP plans involve a network of doctors, health centers, hospitals, skilled nursing facilities and other care providers for the enrolled member to use for their medical needs. 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.

If you wish to have Medicare Part D prescription drug coverage and belong to an HMO, PPO, HMO-POS or SNP, you must get the Part D drug coverage through your plan.

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.

Obtaining Services in Original Medicare vs. Medicare Advantage

Original Medicare entitles the beneficiary to obtain 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 15), can cover all or most of the senior's share of the costs. Medicare Advantage plans are managed care plans, and operate very differently. Medicare Advantage plans employ different models of managed care:

HMOs require the Medicare beneficiary to select a primary care physician (PCP) from the HMO's network of local doctors. Some HMOs require that the PCP provide a referral to

specialists. Since the HMO receives a subsidy from the federal government, costs to the beneficiary may be lower than in fee-for-service Medicare. An HMO may offer additional benefits to those offered in fee-for-service Medicare, such as hearing aids, vision and dental care. 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 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.) Additional health benefits may be included in a PPO's plan, such as hearing aids, vision and dental care.

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. HMO-POS plans may not cover all benefits out-of-network. For example, a plan may only offer in-network inpatient hospital coverage.

Special Needs Plans (SNP) are Medicare Advantage plans (HMOs or PPOs) 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 prescription drug coverage. They 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.

Frequently Asked Questions about Medicare Advantage Plans

Who is eligible to enroll in a Medicare Advantage plan?

In order to be eligible to enroll in a Medicare Advantage plan, you must have both Medicare Part A and Part B; you must live in the plan's service area; and you cannot have permanent kidney failure. A Medicare Advantage plan cannot turn away an applicant because of health problems.

How is a Medicare Advantage plan paid?

When you choose to join a Medicare Advantage plan, the Centers for Medicare and Medicaid Services (CMS) pays the company a set amount each month to cover the medical services the average beneficiary is expected to need.

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 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, 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 2018, maximum out-of-pocket costs (MOOP) cannot exceed $6,700 in-network for HMO plans and $10,000 combined in-network and out-of-network for PPO plans.

How does a Medicare HMO work?

In an HMO, you select a Primary Care Physician (PCP) who is responsible for managing your medical care, admitting you to a hospital, ordering diagnostic tests and treatments, providing referrals to specialists, and writing your prescriptions. You have a choice of physician, provided he or she is available for patients who are new to Medicare. You must receive your health care from the HMO's providers; neither the HMO nor Medicare will pay for services from providers who are not part of the HMO's health care network, except in emergency situations.

How does a Medicare PPO work?

A PPO is a network of doctors, hospitals and other providers. The enrollee can get services from within the network or go out-of-network. If you stay within the PPO's network, you will pay a co-payment (a set amount for certain services) that is probably less than the cost-sharing in "original" Medicare. If you go outside of the PPO's network with a referral to another provider or select another doctor or specialist, you may have to meet the plan's deductible and then pay a higher fee for these services. The PPO will pay a set amount of the fee and you will pay the balance.

How do Medicare Advantage plans work with Medicare Part D (drug coverage)?
If you are in a Medicare Advantage plan and want to have prescription drug coverage, you must get that coverage through your plan; you cannot join a separate Part D (stand-alone) plan.

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 can I appeal a decision by my health plan?
Decisions by your plan not to provide or pay for a service are handled by the plan's claims department. If you are refused Medicare-covered services or denied payment for Medicare-covered supplies or treatments, you must be given a notice which will include your right to appeal.

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.

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; hospital's participation in the plan; prescription drug coverage; finances; and geographical location. <u>It is vital to review this information each year.</u>

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.
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).
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.

What if I want to leave my Medicare Advantage plan?

- From October 15-December 7, you can change your Medicare Advantage (MA) plan choice or return to Original Medicare, with the change effective January 1. You can do this by calling 1-800-Medicare, enrolling online at www.Medicare.gov, or by calling the plan in which you want to enroll.
- From January 1-February 14, Medicare Advantage enrollees have one additional opportunity to return to original Medicare, with the change effective the first of the following month, either February 1 or March 1. To make this change, simply enroll in a Part D plan that works with original Medicare; this enrollment will automatically disenroll you from the Medicare Advantage plan.
- Individuals with Medicaid, a Medicare Savings Program or Extra Help can switch plans at any time, with the change effective the first of the following month.

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, as Medigap coverage would duplicate your benefits. 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 15.

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). A result of the Medicare Modernization Act of 2003, Medicare Part D adds prescription drug coverage benefits to Medicare's existing health benefits of Part A (hospitalization), Part B (outpatient services), and Medicare Advantage Plans. 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 unlike Parts A or B, as it is not standardized nationally but instead is offered through private-sector companies. Each private company designs its own plan for Medicare consumers. These plans have all entered into a contract with the federal government to provide Medicare Part D drug coverage through the Centers for Medicare and Medicaid Services (CMS) which regulates the plans and categories of covered drugs. When you sign up for a Part D plan, you are applying directly to a private company who negotiates the costs of your drugs with pharmacies, and 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 own special needs.

Medicare Part D is offered in one of two ways:

1. **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.
2. **Stand Alone Prescription Drug Plans (PDPs):** these plans ONLY cover prescription drugs and work with original Medicare.

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 drugs 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 $85,000 for an individual or $170,000 for a couple) will pay a surcharge for Part D in addition to their plan premium. The surcharge ranges from $13 to $74.80 per month in 2018, and may be paid in the same way as the Part B premium, typically as a deduction from one's Social Security check (see page 63 for rate chart), but may be paid directly to the Part D insurer.

Although Part D plans' benefit designs vary, they each include the following minimum levels of coverage in 2018:

- **Deductible** (up to $405). This is the amount that you have to pay out-of-pocket before your plan helps pays for the cost of your drugs. Some plans have a lower deductible or no deductible.
- **Initial Coverage Level**. You pay a fixed copay of up to 25% of drug costs up to $3,750 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** (also known as the "donut hole"). After $3,750 in total drug costs, you pay about 35% of brand name drug costs and 44% of generic drug cost (plus a nominal pharmacy dispensing fee), until **you** have incurred $5,000 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 $5,000 in out-of-pocket expenses). The beneficiary is responsible for the greater of five percent (5%) of drug costs or a copay of $3.35 for generic medications and $8.35 for brand-name drugs.

The coverage gap is being gradually reduced. In 2020 there will be a flat 25% co-payment for both brand and generic drugs until the catastrophic coverage is reached.

Enrollment in Medicare Part D

Enrollment in Medicare prescription drug coverage involves choosing a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage prescription drug plan (MA-PD) offering drug coverage. Comparison information is available on www.medicare.gov or by calling 1-800-MEDICARE. You may also contact HIICAP for assistance by calling 311.

Enrollment in Part D can occur during one's seven-month Initial Enrollment Period (IEP), (see page 4). In addition, a beneficiary may join or change plans once each year between October 15 and December 7, during the Annual Coordinated Election Period (AEP). There are also limited exceptions where a beneficiary would be granted a Special Enrollment Period (SEP) to enroll in a Medicare Prescription Drug Plan or to switch plans outside of the AEP. These include the following situations:

- Dual eligible beneficiaries (those with **both** Medicare **and** full Medicaid), individuals in a Medicare Savings Program (QMB, SLMB, or QI), and those with Extra Help, can switch plans as often as every month, to be effective the first of the following month.
- EPIC members can change Part D plans once in a calendar year.
- 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:

- Electronically on the internet, either through www.medicare.gov or the plan's website. HIICAP can assist you with online enrollment.
- 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 or at a sales/marketing event.

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 coverage (coverage for prescription drugs that is at least as good as the standard Medicare prescription drug coverage), they will have to pay a penalty if they choose to enroll later. The penalty is equivalent to one percent (1%) of the "base premium" ($35.02 in 2018) 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.

Anyone who enrolls in Part D during the Part D 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.

Cost utilization management tools

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

- **Tiers:** Most 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.

How do I select a Part D plan?

To select a Part D plan for your specific needs, it is best to use the personalized plan finder tool at www.medicare.gov. You can either do a "Personalized Search," whereby you input your personal Medicare information, or a "General Search," for which you don't need any of your personal Medicare information.

You will input the names of the medications you are currently taking or expect to take in the upcoming year, along with the dosages and quantities needed for a 30-day supply. 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 two pharmacies that you would like to include in your search. After you have input all of the information, the plan finder will provide a listing of the Part D plans, sorted from least expensive to most expensive. It is important to look at the details of each plan to understand what cost utilization management tools, 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. If you would like help using the plan finder, please contact a HIICAP counselor by calling 311 and asking for HIICAP.

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 a Part D prescription drug insurance plan 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. Also remember that you may face a late enrollment penalty if you do not enroll when you are first eligible.

Extra Help with Drug Plan Costs for People with Limited Incomes

The Social Security Administration (SSA), through which people sign up for Medicare Parts A and B, 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.

Individuals with monthly incomes up to 135% of the Federal Poverty Level, $1,356 ($1,827 for couples) in 2017, and resources up to $9,060 ($14,340 for couples) in 2018 may qualify for **full Extra Help**. Those qualifying for full Extra Help will not have a monthly premium for their Part D plan, as long as the plan selected is considered a "benchmark" plan. A benchmark plan is a Part D plan that has been designated by Medicare to meet certain coverage requirements and has a monthly premium that is fully subsidized by Extra Help (monthly premium up to $38.98 in 2018). In 2018, there is a "de minimis" amount of $2, meaning that if the plan's premium is up to $2 over the benchmark amount, the beneficiary may not be responsible to pay that amount, so long as the plan agrees to forego payment of the additional premium. Individuals with full Extra Help will not be subject to the plan's deductible. Full Extra Help beneficiaries with incomes up to 100% of the Federal Poverty Level will have co-pays of $1.25 for generic prescriptions and $3.70 for brand name prescriptions. All others with full Extra Help will have co-pays limited to $3.35 for generic prescriptions and $8.35 for brand name prescriptions.

Individuals with monthly incomes up to 150% of the Federal Poverty Level, $1,507 ($2,030 for couples) in 2017, and resources up to $14,100 ($27,150 for couples) in 2018 may qualify for **partial Extra Help**. Those with partial Extra Help will pay a monthly premium on a sliding scale based on their income. In addition, they will be responsible for a deductible of up to $83 and reduced co-pays of 15% of drug costs until they reach catastrophic levels, after which they pay the standard co-pay amounts.

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, and if you qualify, you will receive a Special Enrollment Period for selecting a Medicare Part D drug plan, and you may change your Part D plan at any time of the year. Individuals with Extra Help will not be subject to a late enrollment penalty in Part D.

There are cases where someone is eligible for Extra Help but not enrolled in a Part D plan – perhaps with Medicaid, SSI, or a Medicare Savings Program. 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. EPIC enrollees may purchase prescriptions at 4,500 participating pharmacies across New York.

EPIC works as secondary coverage to Medicare Part D to lower drug costs. 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 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. Members pay a reduced price for prescriptions depending on the cost of the medication under their Part D plan. For example: for a prescription costing between $15 and $35, they pay $7. The highest EPIC co-pay is $20 for a 30-day prescription, regardless of the price of the prescription under the Part D plan.

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. After paying the fee, participants pay the EPIC co-pay for their medications. 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.

EPIC pays the Part D monthly premium for Fee Plan members, up to $38.98 per month in 2018. In addition, EPIC members with full Extra Help (see page 31) will have their EPIC fees waived.

EPIC's Deductible Plan is for individuals with annual incomes between $20,001 and $75,000, and married couples with incomes between $26,001 and $100,000. To participate in the Deductible Plan, participants pay for their prescriptions until they meet

their EPIC deductible amount, which is based on the previous year's income. After meeting the deductible, participants pay only the EPIC co-pay. For example, a single person with an income of $23,000 must meet an annual deductible of $580. For a married couple with an income of $29,000, each person must meet an annual deductible of $700. There is no fee to join the deductible plan.

EPIC pays the Part D monthly premium (up to $38.98 per month in 2018) 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 (approximately $468 in 2018).

After a Deductible Plan member reaches his/her deductible, all that they will need to pay is the EPIC co-payments for covered drugs. 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 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 Plan 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 "donut hole" (the Part D coverage gap), and during catastrophic coverage, as long as the drugs are first covered by your Part D plan. Approved Part D excluded drugs can be covered by EPIC first for those enrolled in Part D drug plans. 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 "SPAP" (State Pharmaceutical Assistance Program). 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 stand- alone Part D plan) one additional time each year.

EPIC and Extra Help

EPIC members who appear to be income eligible for Extra Help for paying for Medicare Part D costs (see page 31) are required to complete an additional form called Request for Additional Information (RFAI) so that EPIC can apply to the Social Security Administration for Extra Help on their behalf. The application for Extra Help will also be submitted to New York State's Medicaid program to assess eligibility for a Medicare Savings Program (see page 36) 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 type of 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 www.health.ny.gov/health_care/epic/application_contact.htm 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.

BigAppleRx
PRESCRIPTION DRUG DISCOUNT CARD

BigAppleRx is a free New York City sponsored prescription drug discount card. The Big Apple Rx card is free and available to everyone living in, working in or visiting the City, regardless of age, income, citizenship or health insurance status. No personal information or enrollment is required to use the card. The card is accepted at more than 2,000 pharmacies, including chain and independent stores throughout the five boroughs. Only one card is needed per family and there is no limit as to how many times the card can be used.

The card is not insurance. When the card is presented at a participating pharmacy, a discount is taken off the regular price of the prescription. Consumers can save on average 18% on brand name drugs and 55% on generics. Discounts also apply to over-the-counter medications such as smoking cessation aids and diabetic supplies with a doctor's prescription. Cardholders can also purchase prescription through a mail order service and at participating pharmacies nationwide.

The card cannot be used in combination with any other discount card or with insurance. However, it can be used to get medications that the user's insurance does not pay for, or to purchase items that would be less expensive using the card than using the consumer's prescription drug insurance plan. Those with Medicare Part D can use the card to save on prescriptions if/when they have to pay the full cost of their medications.

Receipts from using the Card might count toward meeting an insurance plan's deductible. Consumers should first check with their insurer to find out whether their plan would accept such receipts.

TIP:
If you have an IDNYC card, you may use your IDNYC card for the same discount as BigAppleRx. Simply show the BIN and GRP numbers on the back of your card to the pharmacist.

By visiting www.BigAppleRx.com or calling 311 or 1-888-454-5602, you can:

- Get more information on the BigAppleRx card.
- Get a card.
- Find a participating local pharmacy.
- Find out how much a prescription would cost using the card.

MEDICARE SAVINGS PROGRAMS

Medicare Savings Programs (MSP) can help eligible clients pay for their Medicare premiums and other costs associated with Medicare. MSPs are administered by the Human Resources Administration (HRA) in New York City.

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.
- **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.
- **Qualified Working and Disabled Individual (QWDI):** This program pays for the Medicare Part A premium only, not Part B. The applicant must be a disabled worker under age 65 who lost Part A benefits because of return to work.

2017 MSP Monthly Income and Resource Limits (after any deductions/exclusions)				
	Single		**Married Couple**	
	Income	Resources	Income	Resources
QMB: 100% FPL	$1,005	No Limit	$1,353	No Limit
SLMB:120% FPL	$1,206	No Limit	$1,624	No Limit
QI: 135% FPL	$1,356	No Limit	$1,827	No Limit

Applying for a Medicare Savings Program

- MSP applicants can apply through a Deputized representative, at the local Medicaid office, or by mail.
- A Deputized Representative will assist you with completing the application and collecting the necessary supporting documents. To make an appointment with a deputized HIICAP counselor, call 311 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. Call 347-396-4705 to locate a center near your home where you can get assistance completing the application.

- Mail your 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/health_care/medicaid/program/update/savingsprogram/msapp.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.

Medicare Savings Program advocacy tips:

- Individuals in an MSP are automatically eligible for full Extra Help for paying for Medicare Part D prescription drug coverage (see page 31).
- If you apply for Extra Help at a Social Security Administration you can be considered as applying for QMB, SLMB or QI. SSA will forward your information to New York State to be considered for MSP eligibility.
- You do not need to go to a Medicaid office to apply for an MSP.
- Even if you are still working you may qualify for a Medicare Savings Program.

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.
- 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 you are working full time.

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 other patients. Not adjusting accounts when errors are found.
- Routinely waiving the 20% co-insurance and deductibles.

Medicare Do's and Don'ts

- Never give your Medicare number to people you don't know.
- 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 1-877-678-4697. 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 Medicare 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 1-877-678-4697.

To report Fraud & Abuse with Medicare Part D plans,
Call Medic at 1-877-7SafeRx.

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

IDENTITY THEFT

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

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

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.

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 $842 for single individuals/$1,233 for married couples, and an **asset** limit of $15,150 (plus $1,500 in a burial fund) for single individuals/ $22,200 (plus $3,000 in burial funds) for married couples in 2018.

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 (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 a complete listing of how Medicaid counts income and assets, visit the Medicaid Reference Guide at https://www.health.ny.gov/health_care/medicaid/reference/mrg/.

If your income and/or resources 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 36 for more information).

The Medicaid application

Applicants complete the Access NY Health Care application, form DOH 4220, as well as Supplement A. You can access the applications and instructions, in both English and Spanish, at https://www.health.ny.gov/forms/doh-4220all.pdf.

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 http://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 70 for a list of Medicaid offices, or call 311 and ask for the Human Resources Administration, or visit http://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 should mail a recertification packet in the mail that must be completed in order for ongoing coverage to be determined.

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 comprehensive benefits, such as home health care, and dental and vision services.

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, understanding that dual eligibles can change how they get their coverage at any time of the year:

- Original Medicare (red, white, and blue card) + Fee for service Medicaid (NYS Benefits Card) + Medicare Part D Plan.
- Special Needs Plan specifically designed for dual eligibles - these are HMOs that provide all Medicare A + B + D benefits, as well as the full range of Medicaid covered services.
- Medicare Advantage Plan (with Part D) + fee-for-service Medicaid (NYS Benefits Card).

How does Medicaid interact with Medicare Part D?

Dual eligibles are automatically enrolled in full Extra Help (see page 31) 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, and only pay modest co-pays for their prescriptions. Dual eligibles with incomes under 100% of the Federal Poverty Level (FPL) will have co-pays of $1.25 for generic/$3.70 for brand name prescriptions in 2018. Those with incomes over 100% FPL will have co-pays of $3.35 for generic/$8.35 for brand name prescriptions. Duals will no longer pay co-pays once the total cost of covered drugs reaches the catastrophic level of $7,508.75 in 2018.

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.

Dual eligibles can change plans as often as every month, with the new coverage effective the first of the following month. (Note: Individuals with Medicaid-only do not enroll in a Medicare Part D plan.)

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

Dual eligibles in need of Medicaid-covered personal case, 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 required to enroll in a 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 **four 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. MLTC enrollees will continue to use their current plan (i.e. your Medicare card, your Medicaid card, or your Medicare Advantage card) for all other Medicare and Medicaid services. Individuals who do not enroll in a managed long-term care plan on their own, will be automatically enrolled into an MLTC plan. This is the most flexible of the managed long-term care plan options, as you can maintain you current Medicare and Medicaid provider arrangements.
   - **Medicaid Advantage Plus (MAPlus):** MAPlus plans provide ALL Medicaid AND Medicare services, including long-term care services. Members receive all Medicaid and Medicare 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.
   - **Fully Integrated Dual Advantage (FIDA):** FIDA plans provide all Medicare and Medicaid services, including home care services and Medicare Part D drug coverage, in a single plan. There are no copays or deductibles, including for prescription drugs, though prescription drugs need to be on the plan's formulary. In addition, FIDA enrollees will not have to pay the Part B premium, regardless of whether they are enrolled in a Medicare Savings Program (see page 36).

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
- FIDA: https://www.health.ny.gov/health_care/medicaid/redesign/fida/
- Plan Directory: https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

For Medicaid applicants with an **immediate need for home care services**, there is a procedure in place to obtain Medicaid approval within 7 days, and home care approval within 12 days. In addition to submitting the DOH-4220 application, Supplement A and supporting documentation, they must also submit an M11-Q form, signed by a doctor, stating their specific health care needs, as well as an attestation of immediate need for such care. If approved for immediate-need home care, the applicant will receive services paid directly by the NYC Medicaid program, and need not go through the CFEEC or enrollment in a managed care plan. However, after receiving these services for a few months, the individual will be required to switch to managed care to continue receiving them. Here is a link to the HRA Medicaid Alert describing the procedure: www.wnylc.com/health/afile/203/614/.

How will managed long term care work with a Medicaid Spenddown?
Many people have Medicaid with a spenddown to help them pay for Medicaid-covered home care services. These individuals will now 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. First, decide what type of plan would best suit your needs (MLTC, MAPlus, PACE or FIDA).
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 to see your providers. If you wish to enroll in a MAPlus, PACE or FIDA plan, you also need to get your Part D prescription drug coverage through that plan; the planfinder, at www.medicare.gov, should have the prescription drug information for these plans online.
3. To enroll in the plan, call NY Medicaid Choice at 1-888-401-6582. NY Medicaid Choice should also be able to help you select a plan.

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

What if I want to switch managed long term care plans?
You can switch plans whenever you want. Just call the plan you want to join. The change must be requested by the 19th of the month for the new plan to be effective the first of

the following month. 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, mainstream Medicaid (with long-term care services) and FIDA. 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 individuals moving into a nursing home, most of their 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 they have a spouse still living in the home.

The nursing facility should help prepare and submit the application for Institutional Medicaid. The application is the same as for Community Medicaid, but asset documentation for the past 5 years must be provided. This 5-year "look-back period" allows the Medicaid program 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 2018, the total amount of money transferred will be divided by $12,319 to determine the number of months of the penalty period. For example, if an applicant was found to have transferred $123,190 in savings 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.

Once their Institutional Medicaid application has been accepted, individuals will be notified that they must select a managed care plan within 60 days in order to continue receiving Medicaid nursing home care. If they have Medicare, they will have to choose a managed long-term care plan (MLTC, MAPlus, PACE or FIDA). If they want to stay in the same nursing home, they must pick a plan that contracts with that facility. If they choose a plan that does not contract with their nursing home, they will have to move to an in-network nursing home (unless they choose a FIDA plan, since FIDA plans must cover an out-of-network nursing home if that is where the individuals reside when they enroll). NY Medicaid Choice can help individuals pick the best plan for them. If they do not pick a plan, they will be auto-assigned to one that contracts with their nursing home.

NY STATE OF HEALTH/HEALTH INSURANCE EXCHANGE

- **MEDICAID FOR PEOPLE 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, a have a cost sharing structure that can include premiums, deductibles, copayments, and maximum out-of-pocket costs.

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.
- An **Essential Plan**: Income from 138-200% FPL for those under 65. Can apply year-round.
- A **"Qualified Health Plan"** (QHP), with or without a federal subsidy. Can apply only during the annual open enrollment period, unless you have a qualifying event.

NY State of Health will first determine **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**. 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. Anyone who is a citizen or a legal permanent resident residing in New York can purchase a plan through the New York Marketplace.

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.

Under the Federal Affordable Care Act, <u>you cannot be denied health insurance on the basis of a pre-existing condition</u>, 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 through the Marketplace and outside the Marketplace.

Should I consider enrolling in a plan through the Marketplace?

- If you have <u>Medicaid,</u> you do <u>not</u> need to purchase other health insurance.
- If you have <u>Medicare,</u> you do <u>not</u> need to purchase health insurance through the Marketplace. <u>People with Medicare generally CANNOT enroll in a Marketplace plan</u>. 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 (though

you may want to explore supplemental coverage to help pay for what Medicare does not cover). See page 15 for information on Medigap insurance.
- You do not need to enroll in other health insurance if you have comprehensive health insurance coverage through TRICARE, the Veterans Health Program, a plan offered by an employer, insurance that you have bought on your own that is at least at the Bronze level (as determined by the Marketplace - see below), or a grandfathered health plan that was in existence before the health reform law was enacted. If you are unsure whether your coverage is sufficient, it is best to reach out to your plan to verify.

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 ($1,386 monthly for an individual/$1,867 for a couple in 2017) may qualify for Medicaid. There is no asset limit for these populations. Individuals will receive their Medicaid benefits through a managed care plan (HMO), which should be selected at the time of application.

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 higher MAGI levels (see page 46 for more information).

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

Recertifying for Medicaid

Medicaid recertification happens annually. You must respond to mailings in order to be evaluated for ongoing Medicaid benefits.

What happens when I become Medicare eligible due to turning 65 or due to disability?

Individuals with Medicaid through the New York State of Health cannot maintain Marketplace coverage when they turn 65 or get Medicare due to disability. **Exception: Parents/Caretaker relatives of minor children are allowed to maintain Medicaid through the NY State of Health and also have Medicare.**

- **Medicare eligible at 65:** As one approaches 65, one's case is transferred to HRA. HRA will mail forms to be completed to assess whether the individual can remain on Medicaid at the lower, non-MAGI levels (see next section). HRA will give the individual four months of Medicaid eligibility while the assessment takes place. Clients

should respond to any HRA mailings if they wish to be assessed for ongoing Medicaid eligibility. During this time, clients can use their NYS Benefits Card and access fee-for-service Medicaid from any provider who accepts Medicaid. It is recommended that they apply for Medicare Parts A, B and D (Original Medicare or a Medicare Advantage plan) during the 7-month Initial Enrollment Period (see page 4 for more information). If in Original Medicare one may want to consider purchasing a Medigap policy. These individuals will have full Extra Help (see page 31) for the remainder of the calendar year, and NY State of Health will refund the Part B premiums for the period they continue to have Medicaid coverage.

- **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 Medicaid case gets transferred from NY State of Health to HRA. Clients should now use their NY State Benefits Card and access fee-for-service Medicaid from any provider who accepts Medicaid. Medicare is their primary health insurer, and Medicaid is their secondary insurance. They will maintain Medicaid coverage through the end of their 12-month Medicaid authorization period. Respond to HRA mailings to be evaluated 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 incomes 138-200% FPL (between $1,387-$2,010 monthly for single individuals, $1,868-$2,707 monthly for a household of two in 2017). Those in the Essential Plan can select a Basic Health Program in which to enroll. 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 ($1,387-$1,508/month for single individuals, $1,868-$2,030/month for a household of two in 2017) 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 ($1,508-$2,010/month for single individuals, $2,030-$2,707/month for a household of two in 2017) pay $20/month for coverage, $0 deductible, and low copays, with an annual maximum out-of-pocket cost of $2,000.

Essential Plan Enrollees who become Medicare eligible are no longer eligible for the Essential Plan. They will receive a notice from NY State of Health stating that their enrollment is ending. These individuals should enroll in Medicare A, B and D during their 7-month Initial Enrollment Period (see page 4) and may want to consider supplemental insurance coverage.

QUALIFIED HEALTH PLANS

Qualified Heath Plans are available for anyone to purchase; those with annual incomes less than 400% of the Federal Poverty Level ($48,240 for individuals and $98,400 for a family of four in 2017), 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 from November 1, 2017 through December 15, 2017. People enrolled by December 15, 2017 will have coverage effective January 1, 2018. If you do not enroll by December 15, 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:

- They 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 4 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 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. This includes: new applicants who are non-service connected and 0% service connected Veterans without special eligibility factors; Veterans who seek exemption from medication copayments; and Veterans who want to establish eligibility for beneficiary travel. In lieu of annual financial reporting, VA will simply confirm the Veteran's continued ability to pay applicable copayments for health care and medications, as well as eligibility for beneficiary travel benefits, using information obtained from the Internal Revenue Service (IRS) and Social Security Administration (SSA).

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. In 2018, a single person with income up to $16,089 receives free VA prescriptions. Singles with income up to $32,715 without a service connected illness, receive free VA Health care. To learn more about VA national income thresholds and to calculate your specific geographic-based means test (GMT), visit http://nationalincomelimits.vaftl.us/LegacyVAThresholds/Index?FiscalYear=2018.

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

Types of Copayments:

1. **Medication**: Prescription copayment charges were established by Congress. Depending on one's Priority Group, the charge is $8 or $9 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 6, with an annual copayment cap of $960, unless otherwise exempted. Effective February 28, 2017 new copayment charges will be as follows. Copayments will be broken down into three tiers: Tier 1, preferred generics - $5; Tier 2, non-preferred generics - $8; and Tier 3, brand name medications - $11. All charges are still for up to a 30-day supply.

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: Up to $97 per day (Nursing Home, Respite, and Geriatric Evaluation); Outpatient: $15 per day (Adult Day Health Care, Respite, Geriatric Evaluation); and Domiciliary: $5 per day.

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.

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. TRICARE benefits consist of: TRICARE Prime and Prime Remote, TRICARE Reserve Select, and TRICARE for Life. As of January 1, 2018 TRICARE Select will replace TRICARE Extra and TRICARE Standard. The programs differ on the use of a provider networks and cost sharing obligations. Most specialty services require prior authorization or referral. 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 or $50 per person or $100 per family per calendar year. In addition, there is a 25% co-insurance. CHAMPAVA does not maintain a provider listing. Most Medicare and TRICARE providers will also accept CHAMPVA (but be sure you 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

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, unless the individual qualifies for a special enrollment period.

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.

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, but should enroll in Part B within 8 months following the month you start COBRA coverage in order to avoid Medicare's late enrollment penalty. If you have both Medicare and COBRA, Medicare is primary and COBRA is secondary.

HHC Options

HHC Options is a program through the NYC Health and Hospitals Corporation 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 311 and ask for HHC.

Federally Qualified Health Centers

Federally Qualified Health Centers 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 www.gag.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	1-800-856-9981 www.freelancersunion.org

PATIENT RIGHTS AND APPEALS FOR MEDICARE BENEFICIARIES

All Medicare beneficiaries are protected by the same rights, whether you are in the original Medicare plan or a Medicare Advantage plan.

As a Medicare beneficiary, you have the right to:

- Receive all the care necessary for your condition.
- Be fully informed about your medical condition, including treatment options. Learn about coverage and possible costs.
- Receive a written discharge plan from the hospital. Any decision made by the hospital or your HMO or PPO to discharge you must be based solely on your medical need and not on any method of payment.
- Appeal written notices denying coverage for services from hospitals, managed care plans (HMOs) or Medicare carriers.
- Ask for all notices in writing. DO NOT DISREGARD THEM. Any notice must describe how to appeal decisions.
- Under the "Right to Know Law" in New York State, (the Palliative Care Information Act), every terminally ill New Yorker under a doctor's or surgeon's care will be offered full information about hospice care, palliative care for pain reduction and all other appropriate end-of-life options. You also have the right to refuse or withdraw life-sustaining treatment, to have pain medication and to learn more about treatment options.

For quality of care complaints or if you feel your Medicare Part A or B services (either through Original Medicare or Medicare Advantage) 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 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.

Medicare Advantage enrollees may use the plan's appeals process to appeal an inpatient stay denial or they can contact Livanta by noon of the day after the receipt of the NODMAR (Notice of Discharge and Medicare Appeal Rights). Other denied services may be appealed directly to the plan.

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 new 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.

LONG TERM CARE PLANNING

Now that seniors are living longer, many have concerns about how they will manage health care needs and finances as they become less mobile. Long-term care—in one's home, in alternative housing or in a nursing facility—should involve planning. An understanding of the options and the kinds of care, and the financing of such care, will help give seniors greater control over these important issues in their later years. The following is an overview, topic by topic, of the long-term care planning and insurance areas of interest and concern.

What is long-term care?
Long-term care is the kind of daily assistance that an older adult may need when dealing with a prolonged physical illness, a disability, or a cognitive impairment (such as Alzheimer's disease) that can leave a person unable to completely care for himself. Long-term care includes care in a nursing facility, as well as help at home with activities of daily living. Long-term care is generally divided into four categories:

1. **Skilled Nursing Care:** Daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel. The care must be ordered by a doctor.
2. **Intermediate Care:** Occasional nursing and rehabilitative care, which must be based on a doctor's orders, and can only be performed by, or under the supervision of, skilled medical personnel.
3. **Home Health Care:** Usually received at home as part-time skilled nursing care: speech therapy; physical or occupational therapy; part-time services from home health aides or help from homemakers or chore-workers.
4. **Custodial Care:** Care to help individuals meet personal needs such as walking, bathing, dressing, eating or taking medicine. It can usually be provided by someone without professional medical skills or training.

What are the costs of long-term care?
Arrangements for a home health aide on a private pay basis depend on the hours, level of services and skills required. If the health care provider comes from a certified home health agency where costs are paid through Medicare or Medicaid, the fees are set by the agency and government standards. Private care is $20+ per hour for custodial services. Skilled care from therapists or visiting nurses, for example could cost $100-150 per visit.

Nursing home costs in the New York City area average $125,000-$180,000 per year. An older adult requiring a nursing home placement must cover these costs either by paying from personal income and assets, having long-term care insurance or having Medicaid coverage.

Who pays for long-term care?

Medicare

Medicare's coverage for long-term care is strictly limited to "medically necessary," prescribed circumstances.

Care in the home is covered by Medicare when:

1. The care needed is intermittent skilled nursing care - physical therapy, occupational therapy, speech therapy, monitoring of condition, changing bandages, giving injections, and checking on equipment. "Intermittent" is defined as less than seven days per week, not to exceed 28 hours in any week. Medicare can approve more hours of care per week, but for a shorter period of time. Typically, Medicare approves on average of 8-12 hours of care per week.
2. The beneficiary is unable to leave his home except with the assistance of another person or a wheelchair, for example.
3. The doctor determines that the beneficiary needs home health care and prescribes a home health plan of treatment.
4. The services are provided by a Certified Home Health Agency (CHHA) participating in Medicare.

Care in a skilled nursing facility is covered by Medicare Part A when:

1. The beneficiary is admitted within thirty days after a minimum 3-day hospital stay.
2. The doctor documents that the patient requires a skilled level of care; custodial care can also be involved.
3. The care is provided in a Medicare-certified skilled nursing facility.
4. Medicare coverage is for up to 100 days in a benefit period, with cost-sharing between Medicare and the beneficiary from days 21-100.

Medicare Supplement Insurance ("Medigap")

Since 2010, no new Medigap policies cover an at-home recovery benefit. However, for individuals with older Medigap plans, (D, G, I and J,) their policies may offer coverage, which provides an at-home recovery benefit paying up to $40 per visit, up to $1,600 per year, for personal care services when Medicare covers skilled home health care after an illness or injury. Personal care refers to help with activities of daily living, which includes bathing, dressing, eating, toileting and transferring. In order for the Medigap plan to cover any home health care, the beneficiary must first qualify for skilled home health care under Medicare.

Medicaid

Medicaid is the joint federal/state/city funded program that covers all of the health care and long term care needs of persons with low income and limited assets. To qualify for Medicaid as a senior residing at home in the community, the individual must apply and document financial eligibility, along with other criteria. The home health care benefit under Medicaid is available after the treating doctor prescribes the need for skilled and personal care services which can be provided in the individual's home.

In order for Medicaid to cover the cost of a nursing home stay, the individual must meet the applicable income and resource requirements. Individuals must contribute most of their income to the cost of care, retaining only a modest allowance for personal needs. For more information on Medicaid long term care, see page 42.

Medicaid transfer of asset restrictions: Faced with the prospect of the high costs of long-term care in a nursing home and home care, individuals with accumulated assets sometimes consider a transfer of these assets to family members in order to qualify for Medicaid coverage. A caution: **to be a legitimate transfer**, the senior cannot dictate the family member's use of the funds and the senior, in turn, cannot receive any amount "paid back" from that transfer.

New York State law imposes the following requirements and sanctions if a person transfers assets to become Medicaid-eligible for the purposes of receiving institutional services (note that there is no transfer of asset penalty to receive community Medicaid):

- Transfers to a trust made less than 60 months before you apply for Medicaid will result in a penalty waiting period.
- Medicaid will look at assets transferred 60 months prior to the month of application. If assets were transferred during the applicable lookback period, the applicant will be subject to a penalty period, starting on the date the transfer was made. Medicaid coverage will be refused for the number of months the assets would have paid for care in a nursing home.

Planning Option Eliminates "Surplus Income" 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**. It is no longer necessary 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, reach out to the Evelyn Frank Legal Resources Program at NY Legal Assistance Group at 212-613-7310.

Community spouse protection: When a husband or wife 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 2018 under Medicaid, the community spouse may retain a minimum of $74,820 and a maximum of $123,600 in assets and $3,090 per month in income. However, when both spouses are in a home care situation, the

Community Spouse Protection does not apply. When one or both spouses are receiving care at home under the Medicaid program, they are allowed to keep income and resources only at the Medicaid-eligible levels (see page 40).

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.

MEDICARE 2018

ORIGINAL MEDICARE DEDUCTIBLES, CO-INSURANCE & PREMIUM AMOUNTS

Part A: Hospital Insurance

Deductible	$1,340 per benefit period
Co-Payment	$335 per day for days 61-90 of each benefit period
	$670 per day for each "lifetime reserve day"
Skilled Nursing Facility Co-Pay	$167.50 per day for days 21-100 of each benefit period

Part B: Medical Insurance

Monthly Premium	Medicare beneficiaries will pay a premium of $134, except for: • Those whose Social Security Cost of Living Adjustment (COLA) didn't increase enough to raise their Part B premiums to the $134 level. • Higher income (over $85,000 single/170,000 married) beneficiaries will pay higher amounts.
Annual Deductible	$183
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 2018, if you have less than 30 quarters of Social Security coverage, your Part A premium will be $422 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium will be $232 per month.

Medicare Savings Programs for Low-Income Medicare Beneficiaries (2017)

	Monthly Income Limit (after any deductions/exclusions)	
	Individual	**Couple**
QMB - Qualified Medicare Beneficiary NY State pays premiums, deductibles and co- insurance for those who are automatically eligible for Part A.	$,1005	$1,353
SLMB - Specified Low-Income Medicare Beneficiary Levels State pays Medicare Part B premium only.	$1,206	$1,624
QI - Qualifying Individuals State pays Medicare Part B premium only.	$1,356	$1,827

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

MEDICAID 2018

Standard Medicaid

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

	Monthly Income	Assets
Individual	$842	$15,150
Couple	$1,233	$22,200

*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; $123,600 maximum **Income**: $3,090 monthly

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

Medicare Part B Premium and Part D Surcharge Chart for Higher Income Medicare Beneficiaries

Modified Adjusted Gross Income (MAGI)	Part B Monthly Premium	Part D (Prescription Drug) Monthly Premium
Individuals with a MAGI of $85,000 or **less**/ Married couples with a MAGI of $170,000 or **less**	2018 Standard Premium = $134	Your Plan Premium
Individuals with a MAGI **above** $85,000 up to $107,000/ Married couples with a MAGI **above** $170,000 up to $214,000	$187.50	Your Plan Premium + $13.00
Individuals with a MAGI **above** $107,000 up to $133,500/ Married couples with a MAGI **above** $214,000 up to $267,000	$267.90	Your Plan Premium + $33.60
Individuals with a MAGI **above** $133,500 up to $160,000/ Married couples with a MAGI **above** $267,000 up to $320,000	$348.30	Your Plan Premium + $54.20
Individuals with a MAGI **above** $160,000/ Married couples with a MAGI **above** $320,000	$428.60	Your Plan Premium +$74.80

For more information visit the Social Security Administration's website at www.ssa.gov.

RESOURCES

NYC HIICAP Helpline http://www.nyc.gov/html/dfta/html/benefits/health.shtml	311 – ask for HIICAP
Department for the Aging www.nyc.gov/aging	311
Access-A-Ride http://web.mta.info/nyct/paratran/guide.htm	1-877-337-2017
Advocacy, Counseling and Entitlement Services Project (ACES)	1-212-614-5552
Attorney General Bureau of Consumer Fraud and Protection www.ag.ny.gov	1-800-771-7755
BigAppleRx Discount Card www.BigAppleRx.com	1-888-454-5602 TTY:1-800-662-1220
Center for the Independence of the Disabled in New York www.cidny.org	1-212-674-2300 or 1-646-442-1520
Centers for Medicare and Medicaid Services (CMS) www.cms.gov	1-800-MEDICARE
Columbia University College Of Dental Medicine's Teaching Clinic www.dental.columbia.edu/teaching-clinics	1-212-305-6100
Community Health Advocates www.communityhealthadvocates.org	1-888-614-5400
Eldercare Locator www.eldercare.gov	1-800-677-1116
Elderly Pharmaceutical Insurance Coverage (EPIC) www.health.state.ny.us/health_care/epic/index.htm	1-800-332-3742
HEAR NOW (provides hearing aids to people with limited resources) www.sotheworldmayhear.org/hearnow/	1-800-328-8602
Health Information Tool for Empowerment (resource directory of free and low cost health and social services) www.HiteSite.org	1-866-370-4483
Health and Hospitals Corporation (HHC Options) http://www.nychealthandhospitals.org/paying-for-your-health-care/hhc-options/	311
HRA Info Line – for all HRA programs, including Food Stamps, Public Assistance and Medicaid	1-718-557-1399
Hospice Foundation of America www.hospicefoundation.org	1-800-854-3402
Independent Consumer Advocacy Network (ICAN) – Medicaid managed long term care ombudsman	1-844-614-8800
LawHelp.org (to search for legal services, including pro bono)	
Legal Services NYC www.legalservicesnyc.org	1-917-661-4500
Limited Income Newly Eligible Transition (LINET) Program (administered by Humana)	1-800-783-1307
Livanta, LLC - (Quality Improvement Organization to appeal hospital discharge and make quality of care complaints)	1-866-815-5440
Medicaid referral for providers accepting Medicaid	1-800-541-2831

Medicaid facilitated enrollers for Aged, Blind and Disabled (can also help with Medicare Savings Program Applications).....	1-347-396-4705
Medicare Fraud Hotline (Office of the Inspector General, DHHS).....	1-800-447-8477
Medicare Hotline.....	1-800-MEDICARE
Medicare Rights Center.....	1-800-333-4114
www.medicarerights.org	
National Council on Aging: www.ncoa.org	
National Health Information Center: www.health.gov/nhic	
New York Connects (long term care services and support; they will make home visits).....	1-800-342-9871
Bronx (Neighborhood SHOPP): 1-347-862-5200	
Brooklyn (JASA): 1-718-671-6200	
Manhattan (NY Foundation for Senior Citizens): 1-212-962-2720	
Queens (Selfhelp Community Services): 1-718-559-4400	
Staten Island (CASC):1-718-489-3954	
New York 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-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
www.health.ny.gov/health_care/medicaid/	
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 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) in NYS.....	1-877-678-4697
Social Security Administration.....	1-800-772-1213
www.socialsecurity.gov	TTY 1-800-325-0778
United States Department of Veterans Affairs.....	1-800-827-1000
www.va.gov	

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

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.

Caring Voice Coalition – May be able to help pay for the cost of some prescriptions for people with certain chronic conditions. Visit www.caringvoice.org or call 1-888-267-1440 for more information.

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 GoodDaysfromCDF.org or call 1-877-968-7233.

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

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

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

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

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

Partnership for Prescription Assistance - Helps people access free or low-cost prescription medications. Also provides links for programs that assist with paying co-payments. www.pparx.org or 1-888-4PPA-NOW

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

Together Rx Access – A prescription drug discount card available to people whose incomes meet the guidelines and who are not on Medicare and have no prescription drug coverage. www.togetherrxaccess.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

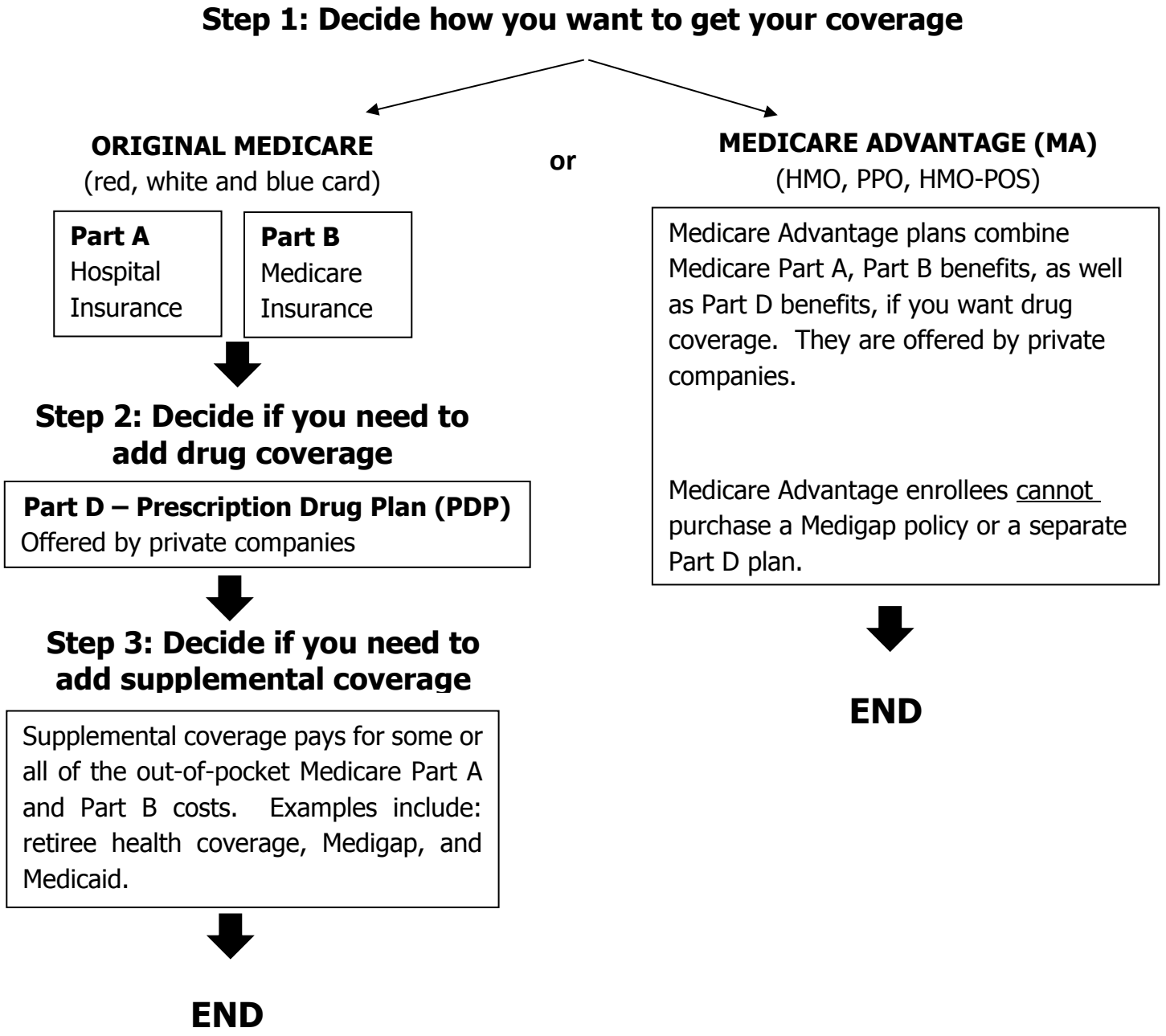
Kaiser Family Foundation - Information on health care policy – www.kff.org

Helpful Health Insurance Definitions

Brand Name Drug	A drug that has a trade name and is protected by a patent. It can be produced and sold only be the company holding the patent.
Co-insurance	An amount that you must pay for medical care. It is a percentage of the total cost of care.
Co-payment	A fixed dollar amount that you pay for a medical service.
Creditable Coverage	Insurance 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. The amounts are not adjusted for living in higher cost areas.
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, and are considered to be as safe and effective as brand name drugs by the federal Food and Drug Administration (FDA).
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 insurance coverage. 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.

MEDICARE COVERAGE CHOICES

Everyone with Medicare has choices in how they get their 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.



Medicaid Offices in New York City

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

Citywide Medicaid Office:

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

Manhattan

- Bellevue Hospital: 462 First Avenue & 27th Street, "G" Link, 1st Fl. (212) 679-7424
  *At printing time, the Bellevue Hospital Medicaid is closed due to Hurricane Sandy. Call prior to visiting.
- Metropolitan Hospital: 1901 First Avenue, 1st Floor, Room 1D-27 (97th Street & 2nd Ave. entrance). (212) 423-7006
- Chinatown Medicaid Office: 115 Chrystie Street, 5 floor. (212) 334-6114
- Manhattanville Medicaid Office: 520-530 West 135th Street, 1st floor. (212) 939-0207

Bronx

- Lincoln Hospital: 234 East 149th Street, Basement, Room B-75. (718) 585-7872
- North Central Bronx Hospital: 3424 Kossuth Avenue, 1st Floor, Room 1A 05. (718) 920-1070
- Morrisania Diagnostic & Treatment Center: 1225 Gerard Avenue, Basement. (718) 960-2799

Brooklyn

- Coney Island Medicaid Office: 3050 West 21st Street. (929) 221-3776
  *The Coney Island Medicaid Office is also open on Saturdays, from 9 am – noon.
- 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
- Brooklyn South Medicaid Office (Central Medicaid Office): 785 Atlantic Avenue, 1st Floor. (929) 221-3502

Queens

- Queens Community Medicaid Office: 32-20 Northern Blvd. (1st Fl.). (718) 784-6729

Staten Island

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

NOTES