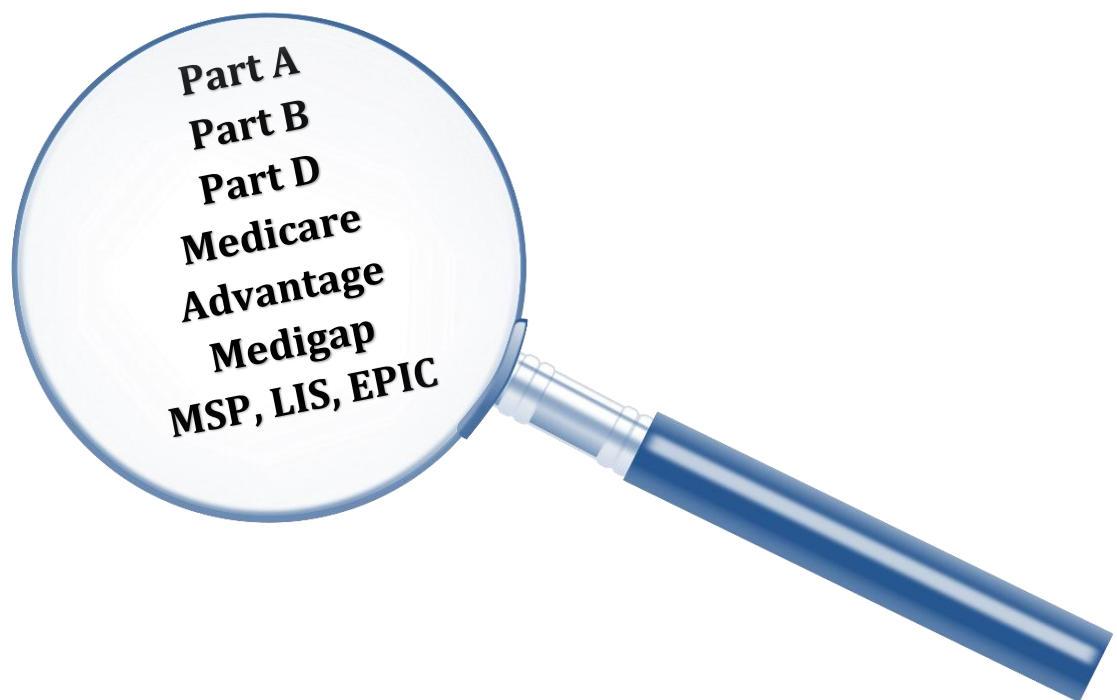


A Closer Look at Medicare and Related Benefits for New Yorkers

2022



Updated March 2022



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



仔細研究紐約人的醫療保險 和相關福利

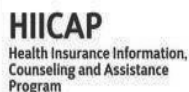
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Disclaimer:

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

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

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

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

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

www.nyc.gov/aging

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免責聲明：

此資料由紐約市長者事務部提供，不得為私人商業目的廣泛分發

本指南由紐約市長者健康保險資訊、諮詢和援助計劃 (*HIICAP*) 部門製定，旨在幫助紐約長者更完善地了解紐約市目前可用的醫療保健保險選項。主題包括醫療保險 A 部分和 B 部分、補充保險、醫療保險優勢計劃、醫療保險 D 部分醫療保險儲蓄計劃和醫療補助。此處詳述的資訊是截至印刷時的最新資訊。使用它身體健康！

HIICAP 是紐約有關長者醫療保健保險的免費、最新和公正資訊的來源。*HIICAP* 幫助熱線可以幫助您回答您的問題。請致電長者化部的長者化聯繫熱線 212-AGING-NYC (212-244-6469)，並要求 *HIICAP* 與我們訓練有素的顧問交談。

我們有 *HIICAP* 輔導員可以通過電話與您交談，或在我們的一個輔導站點與您會面。只需致電我們的幫助熱線，將其轉介給離您最近的輔導員。

請注意，納入特定的醫療保健福利計劃並不構成紐約市長者部對這些計劃的認可。

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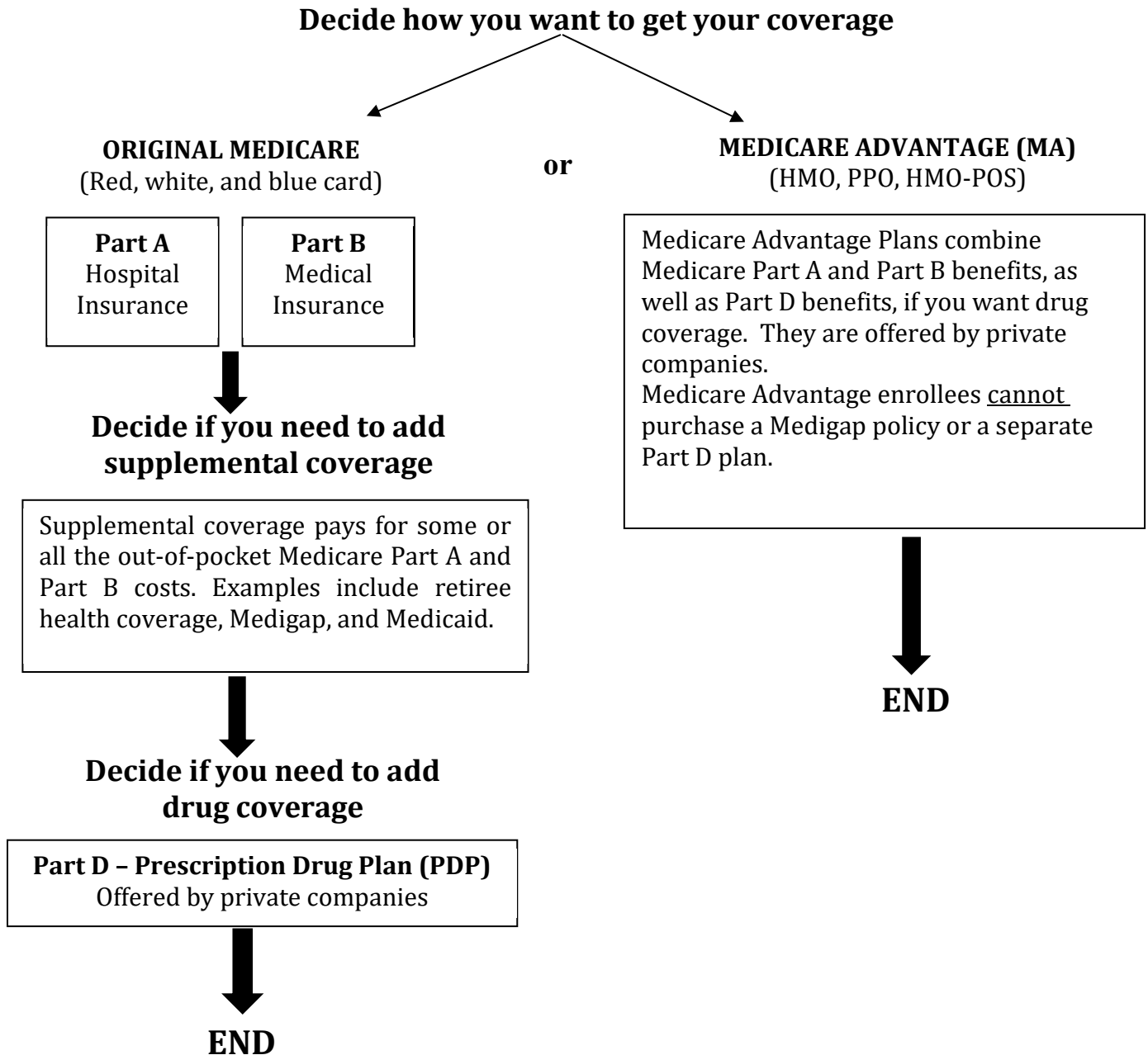
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MEDICARE COVERAGE CHOICES

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

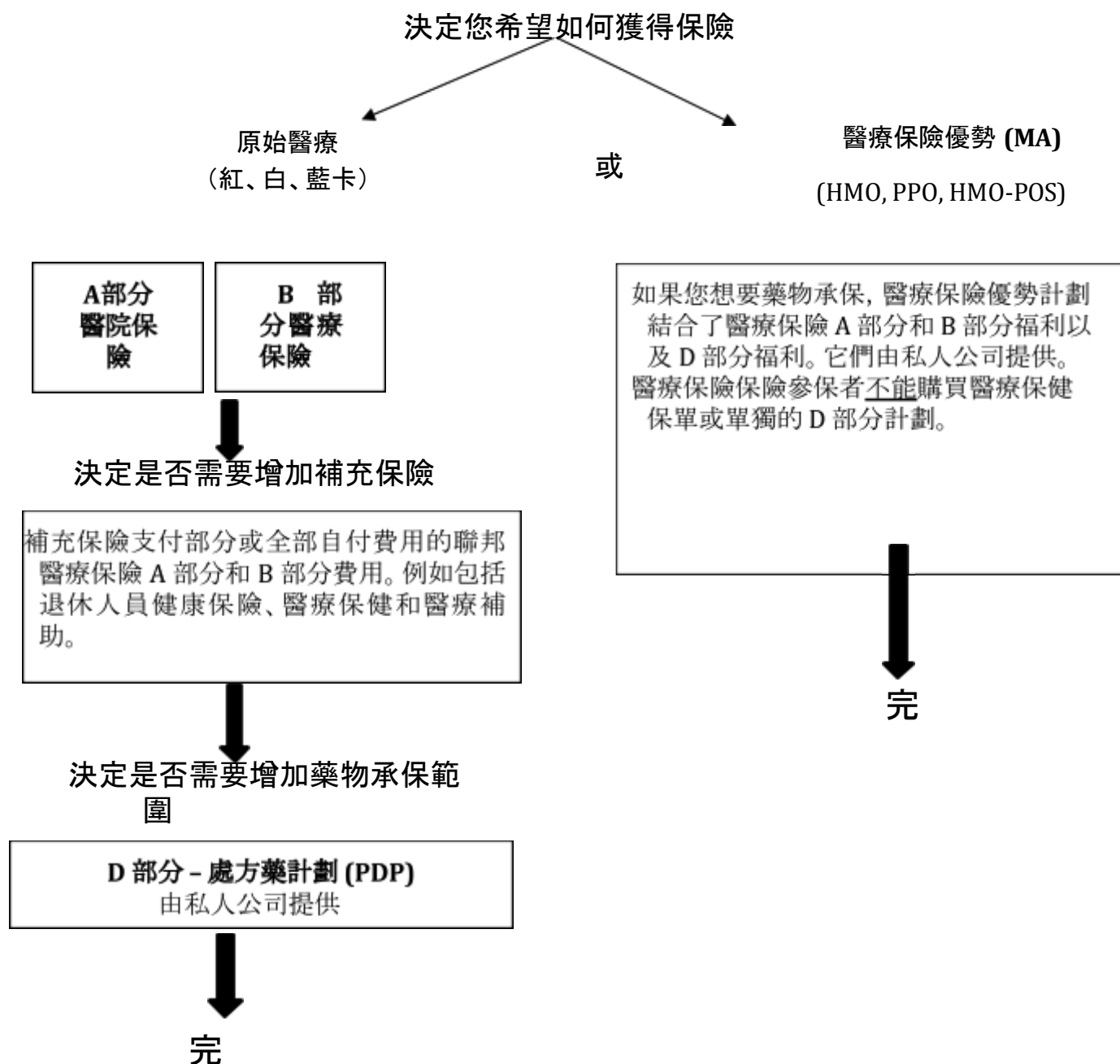
There are two main ways to get your coverage: Original Medicare and a Medicare Advantage Plan. Below is a decision tree to help guide your decision making.



醫療保險範圍選擇

所有醫療保險受益人都可以選擇如何獲得醫療保險。

獲得保險的主要方式有兩種：原始醫療保險和醫療保險優勢計劃。下面是一個決策指南，可幫助指導您的決策。



MEDICARE

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

The main components to Medicare are:

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

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

Who Is Eligible for Medicare?

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

How Eligibility Differs for Part A vs. Part B

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

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

How Do I Enroll in Medicare?

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

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

- If you are already collecting Social Security or Railroad Retirement benefits when you turn 65, you do not have to apply for Medicare. You are enrolled automatically in both Part A and Part B, and your Medicare card is mailed to you about three months before your 65th birthday. Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

醫療保健

醫療保險是一項面向 65 歲及以上人群、某些較年輕的殘疾人和腎功能衰竭(終末期腎病, ESRD) 患者的國家健康保險計劃。

醫療保險的主要組成部分是

- A 部分 - 醫院保險
- B 部分 - 醫療保險
- D 部分 - 處方藥承保範圍

醫療保險受益人可以選擇通過原始醫療保險或醫療保險優勢計劃(有時稱為 C 部分)獲得其醫療保險福利。醫療保險優勢計劃由私人公司管理, 提供所有醫療保險 A 部分和 B 部分福利, 以及 D 部分的藥物覆蓋, 通過管理式醫療。參加 醫療保險優勢計劃的人將通過該私人計劃獲得醫療保險, 而不是通過「原始醫療保險」。請參見第 4 頁的圖表總結了這些選擇。

誰有資格獲得醫療保險？

- 年齡: 如果您年滿 65 歲或以上, 則您有資格獲得醫療保險
 - 美國公民或
 - 合法永久居民(如果沒有資格獲得社會保障, 則至少連續五年)。
- 65歲以下的人有資格獲得醫療保險
 - 接受社會保障殘疾保險(SSDI) 24 個月後。患有肌萎縮側索硬化症(ALS) 的人在接受 SSDI 的第一個月就有資格。
 - 如果他們患有終末期腎病 (ESRD) 並因永久性腎衰竭接受持續透析或進行了腎移植。

A 部分與 B 部分的資格有何不同

- 要在 65 歲時獲得免保費 A 部分的資格, 您或您的配偶必須通過社會保障獲得保險(通過獲得 40 個季度(分)的保險)。如果沒有 40 個季度的承保, 您仍然可以通過在 65 歲時支付 A 部分的保費以獲得醫療保險。
- 您不需要 40 個季度的保險即可獲得 B 部分的資格; 您只需連續五 (5) 年成為美國公民或合法永久居民。

如果您對自己的醫療保險資格有疑問, 或者您想申請 醫療保險, 請致電社會保障局, 電話 1-800-772-1213 (1-800-325-0778 TTY)。您可以在 www.socialsecurity.gov 了解更多資料並申請醫療保險。

我如何加入醫療保險？

有些人會自動加入醫療保險, 而另一些人則需要主動申請。了解 A 部分和 B 部分的註冊規則非常重要, 以避免延遲註冊罰款 (LEP) 和/或出現醫療保險缺口。

在以下情況下首次符合條件時, 人們將自動加入醫療保險:

- 如果您在 65 歲時已經在領取社會保障或鐵路退休福利, 則無需申請醫療保險。您將自動參加 A 部分和 B 部分, 並且您的醫療保險卡會在您 65 歲生日前大約三個月郵寄給您。如果您

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

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

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

Initial Enrollment Period (IEP)

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

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

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

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



正在領取社會保障福利，您必須擁有 A 部分；如果您希望拒絕醫療保險 B 部分福利，請按照醫療保險卡隨附的說明操作。

➤ 如果您領取社會保障殘疾保險 (SSDI) 福利，在您連續 24 個月領取社會保障殘疾福利後，您將自動收到郵寄的醫療保險卡。如果您正在領取社會保障福利，您必須擁有 A 部分；如果您希望拒絕醫療保險 B 部分福利，請按照醫療保險卡隨附的說明操作。

如果您在接近 65 歲時不領取社會保障福利，並且希望在 65 歲時獲得醫療保險福利，那麼了解三個註冊期很重要：初始註冊期、特殊註冊期和一般註冊期。這些詳情如下：

初始註冊期 (IEP)

如果您在 65 歲時未領取社會保障福利，並且希望加入醫療保險 B 部分，則您有七個月的初始註冊期 (IEP) 可以註冊。IEP 包括您年滿 65 歲之前的三個月、您年滿 65 歲的那個月以及之後的三個月。您加入 B 部分的時間將決定您的 B 部分承保何時開始。

- 如果您在生日前三個月註冊，您的醫療保險將在您生日當月的第一天生效。
- 如果您在生日當月註冊，您的保險將在下個月的第一天生效。
- 如果您在生日後的一個月內註冊，您的保險將在兩個月後生效。
- 如果您在生日後兩三個月註冊，您的保險將在三個月後生效。

新資料：從 2023 年開始，在其 IEP 的最後 3 個月註冊的人的 B 部分將在下個月的第一天生效。

注意：對於當月第一天出生的人，醫療保險資格從上個月的第一天開始。



Special Enrollment Period (SEP)

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

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

TIPS for those with employer-based coverage:

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

When Is My Special Enrollment Period?



While you have coverage from your

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

General Enrollment Period (GEP)

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

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

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

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

特殊註冊期(SEP)

如果您通過您或您配偶的目前/活躍僱主或工會購買了健康保險，則您可能無需在首次符合資格時加入醫療保險 B 部分；聯繫您的僱主或工會，詢問是否需要加入 B 部分。

如果您在首次符合醫療保險資格時擁有有效由僱主投保的保險，您將有資格在工作期間或在您失去有效由僱主投保的健康保險的月份後的 8 個月內參加 SEP 參加 B 部分。您需要僱主填寫表格 CMS-L564，記錄由僱主投保的健康保險範圍。表格可在 <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-L564E.pdf> 找到。此表格與 CMS-40B(醫療保險 B 部分註冊申請表)一起提交 <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS40B-E.pdf>，到社會保障，在備註部分指明開始 B 部分保險的所需月份。

對於那些由僱主投保的保險的提示：

- ✓ 如果您參加了醫療保險 A 部分，則您不能再向健康儲蓄賬戶 (HSA) 供款。有關參加 A 部分的資訊，請參閱第 8 頁。
- ✓ COBRA 保險不是來自活躍僱主的健康保險，因此您不符合特殊註冊期的資格。

我的特殊註冊期是什麼時候？



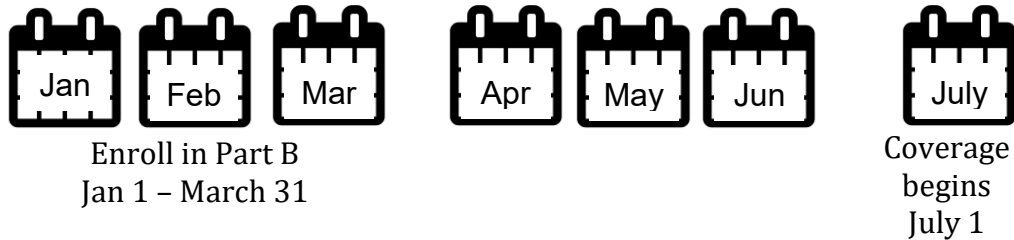
一般註冊期(GEP)

如果您在 IEP 期間未註冊並且由於有效的由僱主投保的保險而沒有資格獲得 SEP，您將必須等到一般註冊期 (GEP) 才能註冊 B 部分。GEP 是從 1 月 1 日到 3 月每年 31 日，但 B 部分的承保要到 7 月 1 日才開始。此外，您可能會受到延遲投保的處罰。如果您沒有獲得醫療保險 B 部分或目前僱主的保險，延遲投保的罰款是目前標準 B 部分保費的 10%，每滿 12 個月。這代表，如果您將 B 部分註冊延遲 12 個月，您將支付 B 部分保費 + 根據當年標準 B 部分保費的 10% 的保費附加費。

新資料：從 2023 年開始，參加 GEP 的人的 B 部分將從下個月的第一天開始生效。

您可以通過聯繫社會保障局申請醫療保險福利。您可以致電 1-800-772-1213 或到訪當地的社會保障辦公室。您也可以 [在 www.socialsecurity.gov 網上註冊](http://www.socialsecurity.gov)。

When is the General Enrollment Period?



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

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

Choices in the Medicare Program

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

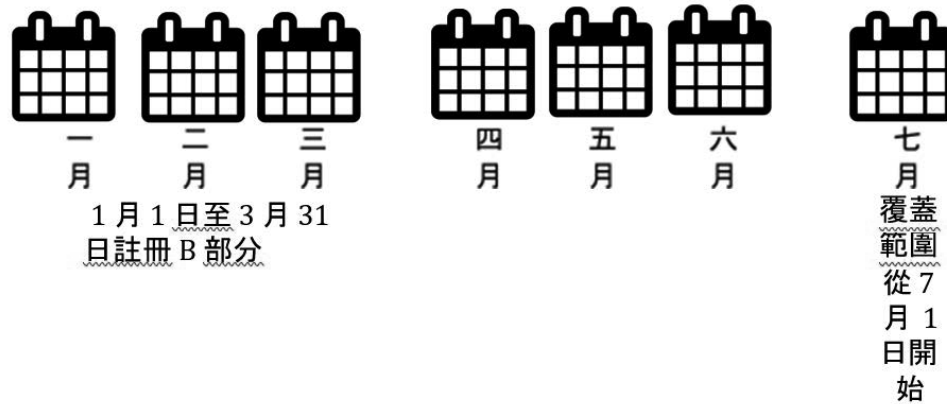
Medicare Part A Benefits

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

Inpatient Hospital Care:

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

一般註冊期是什麼時候？



醫療保險 A 部分註冊:比 B 部分註冊更靈活。有資格在 65 歲時享受免保費 A 部分的人士可以隨時參加聯邦醫療保險A 部分, 並且保險範圍可以追溯至六個月, 但不能在他們符合醫療保險資格的當月之前。那些沒有通過社會保障獲得 40 個季度(分)保險的人可以申請 A 部分並支付保費。這些人只能在初始註冊期間註冊, 之後只能在 1 月 1 日至 3 月 31 日的一般註冊期間註冊。這些人可能會受到延遲註冊處罰。

醫療保險卡:所有醫療保險受益人都應該有一張帶有 ID 號的醫療保險卡, 稱為醫療保險受益人標識符 (MBI)。MBI 由 11 個字符組成, 由大寫字母和數字組成。如果您需要更換您的醫療保險卡, 請致電 1-800-MEDICARE 或登入您的 Medicare.gov 帳戶打印一張。

醫療保險計劃中的選擇

醫療保險受益人可以選擇如何獲得 醫療保險福利(決策指南請參見第 4 頁)。他們可以選擇原始醫療保險, 在其中使用紅色、白色和藍色醫療保險卡享受所有 A 部分和 B 部分承保的服務, 或者他們可以選擇醫療保險優勢計劃, 其中私人公司為他們提供所有醫療保險福利。下面的這一部分解釋了原始醫療保險的運作方式以及原始醫療保險計劃中的費用。有關 醫療保險優勢計劃的資訊, 請參閱第 25 頁。

醫療保險 A 部分福利

醫療保險 A 部分涵蓋住院醫院護理、專業護理機構護理、家庭保健和臨終關懷。

住院治療:

醫療保險支付在福利期內在獲得醫療保險認證的綜合醫院或獲得醫療保險認證的精神病院最多 90 天的必要醫療護理費用。福利期從您入院時開始, 一直持續到您連續 60 天離開醫院或專業護理機構。一個福利期結束後, 只要您下次接受住院治療, 就會開始另一個福利期。醫療保險受益人有 60 個終生儲備日, 可在福利期的第 90 天後使用。

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

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

Skilled Nursing Facility Care:

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

Observation Status

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

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

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

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

醫療保險將為精神病院提供的終生最多 190 天的住院精神病治療支付費用。在精神病院的 190 天護理用完後，醫療保險將僅支付綜合醫院的額外住院精神病護理費用。

在您住院期間，醫療保險A 部分可幫助支付半私人病房、膳食、定期護理服務、康復服務、藥物、醫療用品、實驗室檢查和 X 光檢查的費用。您還可以使用手術室和康復室、心理健康服務、重症監護室和冠心病監護室，以及所有其他醫療必需的服務和用品。

熟練的護理設施護理：

醫療保險 A 部分涵蓋在醫院住院至少三天后在專業護理機構 (SNF) 的護理(不包括出院日)。醫療保險將在福利期內幫助支付最多 100 天的 SNF 費用。

觀察狀態

醫院裡的人可能被認為是住院病人或接受觀察。接受觀察的人接受門診服務，而他們的醫生決定是讓他們住院還是出院。如果醫療保險受益人被觀察超過 24 小時，醫院必須向醫療保險受益人提供醫療保險門診觀察通知 (MOON)。觀察由 B 部分而非 A 部分承保，並且不計入聯邦醫療保險 A 部分所需的最少三天住院時間，以涵蓋在專業護理機構的護理。

家庭醫療保健：如果您在家中並且因受傷或疾病需要專業護理，醫療保險可以支付參與醫療保險的家庭保健機構在您家中提供的護理費用。家庭護理由A 部分或B 部分提供 100% 的承保。無需事先住院即可獲得家庭保健服務。這些服務可以是兼職或間歇性的，而不是全職的。為熟練護理提供保險，包括熟練護理以及身體、職業和言語治療。如果您正在接受熟練的家庭護理，您可能也有資格獲得其他家庭護理服務，例如家庭健康助理和醫療社會工作者。

那些同時擁有醫療保險和醫療補助並接受醫療補助涵蓋的家庭護理服務的人必須參加管理式長期護理 (MLTC) 計劃。有關 MLTC 的更多資訊，請參見第 45 頁。

臨終關懷：身患絕症的醫療保險受益人可以選擇接受臨終關懷，而不是常規的醫療保險福利。臨終關懷強調提供舒適和緩解疼痛。它通常在家裡提供，可以包括身體護理、諮詢、處方藥、設備以及絕症和相關疾病的用品。

Part A Costs (2022)

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

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

Inpatient Costs

Deductible: \$1,556 per benefit period (covers days 1-60)

Additional cost sharing:

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

Skilled Nursing Facility Costs

Days 1–20: Medicare pays 100%

Days 21–100: You pay \$194.50 per day

If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

Medicare Part B Benefits

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

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

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

A 部分費用(2022 年)

保費:如果您或您的配偶已經工作並繳納社會保障金至少 40 個季度(10 年),則免費。

- 社會保障覆蓋面少於 40 個季度的人可以購買 A 部分保險。
 - 如果您的社會保障保險少於 30 個季度,您的A 部分保費將為每月 \$499。如果您有 30 到 39 個季度,您的 A 部分保費將為每月 \$274。
 - QMB 醫療保險儲蓄計劃可能能夠為不符合免保費 A 部分資格的人支付 A 部分保費。請參閱第 38 頁。

住院費用

免賠額:每個福利期 \$1,556(涵蓋第 1-60 天)

額外費用分攤:

- 第 61-90 天每天 \$389
- 每個終身儲備日(60 天)\$778

專業護理設施費用

第 1-20 天:醫療保險支付 100%

第 21-100 天:您每天支付 \$194.50

如果您在福利期內需要超過 100 天的護理,則您需要承擔從第 101 天開始的所有費用。

醫療保險 B 部分福利

醫療保險 B 部分支付範圍廣泛的醫療服務和用品。最重要的是,它有助於支付醫生賬單。無論是在家中、在醫生辦公室、在診所、在療養院還是在醫院,醫生提供的醫療必要服務都將得到承保。B 部分涵蓋:

- | | |
|---------------------|-----------------------------|
| ▪ 救護車運輸 | ▪ 醫療用品(包括與血糖監測儀一起使用的試紙和柳葉刀) |
| ▪ 血, 前 3 品脫後 | ▪ 精神衛生保健 |
| ▪ 耐用醫療設備 | ▪ 門診醫院服務 |
| ▪ 流感、新冠肺炎、肺炎和乙型肝炎疫苗 | ▪ 物理、言語和職業治療 醫師服務 |
| ▪ 家庭護理(見第 9 頁) | ▪ 預防和篩查測試 |
| ▪ 注射劑 | ▪ X 光片 |
| ▪ 實驗室測試(100% 覆蓋) | |

醫療保險不支付常規視力(眼鏡)、助聽器、牙科、常規年度體檢和其他排除服務的費用。

致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

What Do You Pay Under Part B?

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

Part B Costs (2022)

Standard monthly **premium** is \$170.10.

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

Annual Deductible: \$233

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

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

Several resources can help cover the cost-sharing under Original Medicare:

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

How Much Can Providers Charge for Services?

Doctors and other medical providers can choose to have different relationships with the Medicare program. They can be “Participating” providers or “non-Participating” providers, or they can “Opt Out” of the Medicare program. The provider’s relationship affects how much you will pay for his or her services.

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

在 B 部分保險中您需要支付什麼費用？

根據醫療保險 B 部分，受益人負責為大多數服務支付每月保費、每年免賠額和共同保險。領取社會保障福利的受益人會從支票中扣除每月保費。那些不領取社會保障的人通常會按季度支付保費。

B 部分費用(2022 年)

每月標準保費為 170.10 美元。

- 收入較高的人(個人超過 91,000 美元, 夫婦超過 182,000 美元)需要支付較高的保費, 稱為與收入相關的每月調整金額 (IRMAA)。社會保障通過查看兩年前的納稅申報表來確定一個人是否需要繳納 IRMAA; IRMAA 每年都會重新評估。例如, 對於 2022 年, SSA 會查看您 2020 年的稅務申報。您可以通過提交表格 SSA-44 (www.ssa.gov/forms/ssa-44-ext.pdf) 要求 SSA 重新考慮您的 IRMAA 金額, 因為發生了改變生活的事件(例如工作狀態的變化)。有關當前 IRMAA 金額的更多資訊, 請參見第 56 頁。

年度免賠額:233 美元

共同保險:20%(聯邦醫療保險支付聯邦醫療保險批准金額的 80%)

在原始醫療保險下, 您能得到費用分擔方面的幫助嗎？

一些資源可以幫助支付原始醫療保險下的費用分攤：

- 醫療保險補充保險 (補充保險) 幫醫療保險助醫療保險受益人支付其在醫療保險批准的承保服務金額中的份額。這些政策填補了醫療保險報銷的「空白」, 但僅限於批准用於醫療保險承保的服務。有關補充保險政策的資訊, 請參見第 18 頁。
- 退休人員/工會福利可能適用於原始醫療保險。與您的福利管理員聯絡以了解該政策。
- 只要您符合醫療補助資格要求, 醫療補助就可以幫助您分攤醫療保險費用。有關詳細資訊, 請參見第 42 頁。

提供者可以收取多少服務費？

醫生和其他醫療提供者可以選擇與醫療保險計劃建立不同的關係。他們可以是「參與」提供者或「非參與」提供者, 或者他們可以「退出」醫療保險計劃。提供者的關係會影響您為他或她的服務支付的費用。

- 「參與」提供者將始終接受醫療保險允許的全額付款(在您達到 B 部分免賠額後, 醫療保險支付 80%, 您支付 20%)。如果您想了解提供者是否參與, 您可以查看 medicare.gov 網站或致電 1-800-MEDICARE。

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

Advance Beneficiary Notice of Non-Coverage

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

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

Medicare Summary Notice

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

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

Beneficiaries can also call 1-800-MEDICARE or log on to their account on medicare.gov for their
Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

- 「非參與」提供者仍與醫療補助計劃有關係，但他們可以選擇「接受分配」或「不接受分配」對每個索賠。如果您得知提供者不參與，請詢問：「醫生會否接受我的索賠分配？」
 - 如果提供者接受分配，則在您達到 B 部分免賠額後，他或她將接受醫療保險批准的特定服務金額，並且不會向您收取超過 20% 的共同保險（對於大多數服務）。
 - 如果提供者不接受分配，則這些費用將受到「限制費用」的約束，這是超出醫療保險批准金額的額外費用。聯邦限制收費為 15%。包括紐約在內的一些州的限制收費較低。在紐約，如果醫生不接受特定服務的分配，他們可以收取不超過醫療保險允許該服務的費用的 5%，但家庭和辦公室到訪除外，費用最高可達 15% 聯邦限制收費。
 - 注意：不接受分配的提供者在服務時要求付款是很常見的。提供者將向醫療保險提交索賠，醫療保險將向受益人報銷 80%。
- 「選擇退出」醫療保險計劃的提供者必須與任何尋求治療的醫療保險受益人簽訂「私人合同」。他們將為每項特定服務設定費用，並且您同意支付費用，同時理解醫療保險不會向醫生付款或報銷您，並且提供者不受醫療保險限制他們可以收取多少費用。醫療保險補充保險（補充保險）也不會支付任何這些費用。即使選擇退出的提供者可能會轉介其他提供者提供的服務，您仍然可以享受醫療保險的承保。

未承保的提前受益人通知

原始醫療保險沒有事先授權（非常有限的例外）。如果醫療保險認為某項服務在醫學上是必要的，它將支付該服務的費用。如果醫療保險拒絕提供非醫療必要服務，則受益人不負責支付服務費用，除非提供者使用預先受益人通知提前通知了他們。

如果提供者認為醫療保險可能不認為某項服務「具有醫療必要性」，因此不批准索賠，則提供者可能會向您提供「未承保的預先受益人通知（ABN）」表格。該表格必須說明所涉及的服務，以及醫療保險可能不支付服務費用的具體原因。它還必須包括一個供您簽名的地方，以證明您理解並承擔支付服務費用的責任。除非您簽署了有效的 ABN，否則您無需負責付款。ABN 不適用於醫療保險從未涵蓋的服務（例如助聽器），這始終是您的責任。即使有已簽署的 ABN，您仍保留上訴權。有關 ABN 樣本，請參見第 13 頁。

醫療保險摘要通知

鼓勵受益人註冊以網上接收電子醫療保險匯總通知（e-MSN）資訊。否則，每季度將向接受醫療保險分配的提供者提交 A 部分和/或 B 部分索賠的每個醫療保險受益人郵寄一份醫療保險摘要通知（MSN）聲明。對於不接受醫療保險分配的提供者提出的索賠，在處理索賠時將郵寄 MSN 以及一張支票給受益人。

MSN 還包含有關如何對醫療保險索賠被拒提出上訴的資訊。

受益人還可以致電 1-800-MEDICARE 或登入他們在 [medicare.gov](https://www.medicare.gov) 上的帳戶以獲取他們的索賠資訊。他

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

Medicare Appeals

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

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

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

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

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

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

WHAT YOU NEED TO DO NOW:

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

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

- ☐ **OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- ☐ **OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

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

I. Signature:

J. Date:

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

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

Form CMS-R-131 (Exp. 06/30/2023)

Form Approved OMB No. 0938-0566

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

們可以致電 1-800-MEDICARE 請求接收西班牙語版的 MSN。

醫療保險上訴

如果您不同意醫療保險承保範圍或付款決定，您可以向 醫療保險提出上訴。醫療保險摘要通知 (MSN) 包含有關上訴程序的資訊。您可能需要向您的醫療保健提供者索取更多資訊以支持您的案例。請注意提出上訴的時限。

對於護理質量投訴，或者如果您覺得您的醫療保險 A 或 B 部分服務結束得太早，例如，如果您認為自己過早出院，請致電 Livanta，電話 1-877-588-1123 (TTY: 1-855-887-6668)。

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

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

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

WHAT YOU NEED TO DO NOW:

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

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

- ☐ **OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- ☐ **OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

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

I. Signature:

J. Date:

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Form CMS-R-131 (Exp. 06/30/2023)

Form Approved OMB No. 0938-0566

致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

MEDICARE PREVENTIVE SERVICES

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

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

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

醫療保險預防服務

幾乎所有預防性服務都由醫療保險100% 承保, 不受 B 部分免賠額和/或 20% 共同保險的約束。醫療保險為以下預防性服務提供承保:

腹部主動脈瘤篩檢	如果您有腹部主動脈瘤篩家族史或年齡在 65-75 歲之間並一生中至少抽過 100 支香煙, 醫療保險會承保一次腹部主動脈篩檢超聲檢查。
酒精濫用篩查和諮詢	醫療保險涵蓋了酒精濫用的年度篩查。對於那些篩查呈陽性的人, 醫療保險每年還將涵蓋最多四次簡短的面對面行為諮詢干預。
骨量測量	醫療保險承保每 24 個月進行一次骨量測量, 以確定骨質流失或確定骨密度。有骨質疏鬆症風險或正在接受骨質疏鬆症藥物治療的女性可能更頻繁地符合條件。
乳腺癌篩查 (乳房 X 光檢查)	在 35 至 39 歲之間承保一次乳房 X 光檢查。所有 40 歲及以上的醫療保險女性均享有每 12 個月進行一次乳房 X 光檢查的承保。在出現乳腺癌症狀的任何時候, 都可以進行診斷性乳房 X 光檢查。診斷性乳房 X 光檢查受 B 部分免賠額和 20% 共同保險的約束。
心血管疾病 (行為療法)	醫療保險每年承保一次 CVD 風險降低檢查。這次檢查鼓勵使用阿司匹林、篩查高血壓和行為諮詢以促進健康飲食。
心血管疾病篩查	醫療保險承保每 5 年檢查一次膽固醇和其他血脂 (血脂) 水平的心血管篩查。
宮頸癌和陰道癌篩查 (巴氏塗片和盆腔檢查)	每 24 個月承保一次子宮頸抹片檢查、盆腔檢查和臨床乳房檢查, 對於宮頸癌或陰道癌風險較高的女性, 每 12 個月承保一次。所有擁有醫療保險的女性都被覆蓋。 B 部分還涵蓋對 30-65 歲沒有 HPV 症狀的女性每 5 年一次的人乳頭瘤病毒 (HPV) 檢測 (作為巴氏試驗的一部分)。
大腸癌篩查	● 每 12 個月承保一次糞便潛血試驗。 ● 柔性乙狀結腸鏡檢查每 48 個月承保一次。 ● 對於結腸癌風險較高的人, 每 24 個月承保一次結腸鏡檢查。對於那些沒有較高風險的人, 每 10 年承保一次, 但不是在篩查軟式乙狀結腸鏡檢查後的 48 個月內。 ● 銀灌腸造影: 這可以代替靈活的乙狀結腸鏡檢查或結腸鏡檢查; 您支付醫療保險批准金額的 20%。 ● 多目標糞便 DNA 檢測: 每 3 年承保一次, 適用於 50 至 85 歲的醫療保險人群; 沒有結直腸病的跡像或症狀; 並且處於患結直腸癌的平均風險中。
抑鬱症篩查	醫療保險每 12 個月承保一次初級保健機構的抑鬱症篩查。
糖尿病篩查	醫療保險每年最多為有糖尿病風險的人提供 2 次篩查。

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

糖尿病預防計劃	醫療保險承保一項一次性健康行為改變計劃，以幫助符合臨床要求且從未被診斷出患有 1 型或 2 型糖尿病或終末期腎病 (ESRD) 的人預防 2 型糖尿病。
糖尿病自我管理培訓	醫療保險為糖尿病患者提供如何管理病情和預防並發症的培訓。
青光眼測試	青光眼高危人群，包括糖尿病患者或有青光眼家族史的人，每 12 個月承保一次。在 B 部分免賠額之後，您支付醫療保險批准金額的 20%。
乙型肝炎病毒感染篩查	醫療保險為未接種乙肝疫苗的高危人群提供年度乙肝篩查；醫療保險還為孕婦提供乙肝篩查。
丙型肝炎篩查試驗	醫療保險為 1945 年至 1965 年間出生的人提供一項丙型肝炎篩查測試，並為高危人群提供每年一次的重複篩查。
愛滋病毒篩查	要求測試的任何受益人每 12 個月承保一次。
肺癌篩查	醫療保險為目前吸煙或在過去 15 年內戒菸的 50-77 歲人群每 12 個月進行一次肺癌篩查。
醫學營養療法	醫療保險為第一年提供 3 小時的一對一諮詢服務，之後每年為患有糖尿病或腎病的受益人提供 2 小時的諮詢服務。
肥胖篩查和諮詢	如果您的體重指數為 30 或更高，醫療保險涵蓋飲食評估以及強化行為諮詢和行為治療。
體檢	在加入醫療保險 B 部分的前 12 個月內，將承保初次預防性體檢。此外，所有參加醫療保險 B 部分的人都可以進行年度健康檢查，但不是在初次檢查後的 12 個月內。
前列腺癌篩查	對於 50 歲及以上的男性，每 12 個月承保一次直腸指檢。在 B 部分免賠額之後，您支付醫療保險批准金額的 20%。對於 50 歲及以上的男性，每 12 個月承保一次前列腺特定抗原 (PSA) 血液篩查測試。
性傳播感染 (STI) 篩查和諮詢	醫療保險涵蓋衣原體、淋病、梅毒和乙型肝炎的篩查，以及預防性傳播感染的高強度行為諮詢 (HIBC)。篩查測試每 12 個月覆蓋一次，此外，每年最多為兩個人提供 20 到 30 分鐘的諮詢課程，為性傳播感染風險增加的人提供諮詢服務。
戒菸諮詢	醫療保險將在 12 個月內為使用煙草的受益人提供多達 8 次關於戒菸的面對面諮詢。
疫苗接種/注射	新冠肺炎 每個流感季節承保一次流感 肺炎通常一生只需要一次。在您第一次注射後的 12 個月，將承保另一次不同的第二次注射。 如果處於高或中等風險的乙型肝炎是承保的。

MEDICARE AS SECONDARY PAYER WHO PAYS FIRST?

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

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

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

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

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

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

醫療保險作為第二付款人誰先付款？

如果您擁有醫療保險和其他健康保險，您需要了解哪些是主要的，哪些是次要的。主要保險將首先考慮索賠，次要保險將考慮在主要保險支付或拒絕索賠後剩餘的任何餘額。

新加入醫療保險的人士將收到一封郵件，要求他們填寫初始登記問卷 (IEQ)。此問卷詢問您是否通過您的僱主或家庭成員的僱主獲得團體健康計劃保險。IEQ 可以網上完成，在您的 Medicare.gov 帳戶上完成，或致電 1-855-798-2627 通過電話完成。

如果您對誰先付款有疑問，或者如果您的承保範圍發生變化，請致電 1-855-798-2627 聯絡 Medicare 福利協調與恢復中心 (BCRC)。

此圖表顯示在您從目前僱主處獲得醫療保險和保險的情況下誰先付款：

您是…	您的僱主有…	醫療保險將…
由僱主計劃涵蓋的 65 歲以上人士	少於20名員工	先支付 - 僱主計劃其後支付。
由僱主計劃涵蓋的 65 歲以上人士	20名或更多員工	後支付 - 僱主計劃先支付。
由配偶僱主計劃涵蓋的 65 歲以上人士	少於20名員工	先支付 - 僱主計劃其後支付。
由配偶僱主計劃涵蓋的 65 歲以上人士	20名或更多員工	後支付 - 僱主計劃先支付。
由僱主計劃涵蓋的 65 歲以下殘疾人士	少於100名員工	先支付 - 僱主計劃其後支付。
由僱主計劃涵蓋的 65 歲以下殘疾人士	100名或更多員工	後支付 - 僱主計劃先支付。
其他家庭成員計劃承保的 65 歲以下殘障人士	少於100名員工	先支付 - 僱主計劃其後支付。
其他家庭成員計劃承保的 65 歲以下殘障人士	100名或更多員工	後支付 - 僱主計劃先支付。
自己的僱主計劃或家庭成員承保的任何患有終末期腎病 (ESRD) 的年齡	任何數量的員工	如加入醫療保險的前 30 個月後支付。30 個月後，醫療保險將主要支付。

僱主團體健康計劃 (EGHP) 和醫療保險：當人們同時擁有僱主保險和醫療保險時，僱主的規模決定了醫療保險是主要還是次要保險公司。

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

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

- **Disability and Medicare:** If you have health insurance coverage based on your own, your spouse's or another family member's active employment, with an employer of 100 or more employees, the EGHP is primary, and Medicare is secondary. If the employer has fewer than 100 employees, then Medicare is primary and the EGHP is secondary.
- **End Stage Renal Disease (ESRD):** Some individuals are eligible for Medicare coverage because they have End Stage Renal Disease and are either receiving maintenance dialysis treatments or have had a kidney transplant. If they have an EGHP (regardless of whether it is based on current employment), that coverage is primary during the first 30 months of Medicare eligibility. After 30 months, Medicare is primary.
- **Worker's Compensation and Medicare:** Worker's Compensation is usually primary in the event of a job-related injury and covers only health care expenses related to the injury.
- **Liability Insurance and Medicare:** In the case of an accident or injury, medical care expenses may be covered by other types of insurance such as no-fault or automobile insurance, homeowners, or malpractice policies. Since many liability claims take a long time to be settled, Medicare can make conditional payments in this situation to avoid delays in reimbursement to providers and beneficiary liability. Medicare will pay the claim and later seek to recover the conditional payments from the settlement amount. The Benefits Coordination & Recovery Center (BCRC) assists with this function.

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

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

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

- **65 歲後工作人士:**如果您通過您或您配偶的積極就業獲得健康保險, 並且僱主有 20 名或更多員工, 則 EGHP 是主要的, 醫療保險是次要的。如果僱主的僱員少於 20 人, 則醫療保險是主要的, EGHP 是次要的。一些僱主要求有資格獲得醫療保險的僱員參加醫療保險 A 部分和/或 B 部分;建議就這個問題與僱主聯絡。

當您接近退休時, 您需要考慮加入醫療保險 B 部分, 因為這將是您退休時的主要保險。有關醫療保險特殊註冊期的資訊, 請參見第 7 頁。

- **殘疾和醫療保險:**如果您擁有您自己、您的配偶或其他家庭成員的積極就業的健康保險, 並且僱主有 100 名或更多僱員, 則 EGHP 是主要的, 而醫療保險是次要的。如果僱主的僱員少於 100 人, 則醫療保險是主要的, EGHP 是次要的。
- **終末期腎病 (ESRD):**有些人有資格獲得醫療保險, 因為他們患有終末期腎病並且正在接受維持性透析治療或接受過腎移植。如果他們有 EGHP(無論它是否基於當前就業), 則該保險在醫療保險資格的前 30 個月內是次要的。30 個月後, 醫療保險是主要的。

工傷賠償和醫療保險:工傷賠償通常是發生與工作相關的傷害的主要費用, 僅涵蓋與傷害相關的醫療保健費用。

- **責任保險和醫療保險:**在發生事故或受傷的情況下, 醫療費用可能由其他類型的保險承保, 例如無過錯保險或汽車保險、房主保險或醫療事故保險。由於許多責任索賠需要很長時間才能解決, 因此 醫療保險可以在這種情況下進行有條件的付款, 以避免延遲向提供者和受益人的責任報銷。醫療保險將支付索賠, 然後尋求從和解金額中收回有條件的付款。福利協調與恢復中心 (BCRC) 協助執行此功能。

退休人員健康保險:一般來說, 如果您同時擁有醫療保險和退休人員健康保險, 則醫療保險是主要的, 而退休人員的保險則是次要的。一些退休人員福利更像是原始醫療保險的補充, 而另一些則更像是醫療保險優勢計劃。您必須與福利管理員交談, 以了解您的退休人員福利如何與醫療保險協調。

聯邦僱員健康福利 (FEHB):與大多數需要加入醫療保險的退休人員計劃不同, 如果您未加入醫療保險, 聯邦僱員健康福利 (FEHB) 計劃可以繼續作為主要支付。FEHB 退休人員可以選擇參加或不參加 B 部分。他們有三個選擇:

1. FEHB 和 NO B 部分。會員無需註冊醫療保險即可繼續其 FEHB 保險, 這將為他們節省每月 B 部分保費的費用。但是, 如果這些成員後來決定他們想要 B 部分, 他們將需要等到下一個一般註冊期才能註冊 B 部分, 並且可能會受到延遲註冊的處罰。

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

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

MEDICARE SUPPLEMENT INSURANCE (Medigap)

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

Why do I need a Medigap policy?

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

What Medigap plans are available?

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

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

When can I buy a Medigap policy?

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

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

2. FEHB 和 B 部分。會員可以繼續他們的 FEHB 保險，也可以加入 B 部分。一些 FEHB 計劃可能會提供加入醫療保險的激勵措施，例如放棄 FEHB 計劃的共付額、免賠額和共同保險。選擇同時參加醫療保險和 FEHB 的會員需要同時支付 FEHB 和 B 部分保費。
3. B 部分和沒有 FEHB。與大多數退休人員不同，聯邦退休人員可以暫停（而不是取消）他們的退休人員保險以參加醫療保險優勢計劃，該計劃可能每月保費較低或根本不增加保費。選擇此選項的人士仍需要參加 B 部分才能有資格參加醫療保險優勢計劃，但他們將避免 FEHB 保費的更高成本。此外，他們可以選擇在下一個 FEHB 開放註冊期間返回 FEHB 保險。

瀏覽人事管理辦公室 (OPM) 網站，了解有關醫療保險和 FEHB 的更多資訊，網址為 <http://www.opm.gov/insure/health/medicare/index.asp>,
<http://www.opm.gov/healthcare-insurance/fastfacts/fehbmedicare.pdf>,
and <http://www.opm.gov/healthcare-insurance/healthcare/medicare/75-12-final.pdf>.

聯邦醫療補充保險 (補充保險)

醫療保險補充保險 (補充保險) 專門用於幫助分攤與原始醫療保險 A 部分和 B 部分相關的費用。受聯邦和州法律監管，這些保單只能從私人公司購買。您必須擁有醫療保險 A 和 B 部分才能購買補充保險保單。今天出售的補充保險保單不包括藥物保險。

為什麼我需要 補充保險保單？

補充保險保單支付您在醫療保險承保的自付費用醫療服務費用中的份額。例如，補充保險保單可能涵蓋 A 部分免賠額、B 部分允許費用的 20% 的門診共同保險以及其他費用。注意：一些計劃僅涵蓋這些費用的一部分，而其他計劃則完全涵蓋這些費用。醫療保險優勢計劃參保者不應加入補充保險計劃，因為這會重複覆蓋，他們通過醫療保險優勢計劃獲得。

有哪些補充保險計劃提供？

有十個標準 補充保險計劃可用，指定為「A」到「N」。所有計劃都涵蓋基本福利包：計劃 B 到 N 將其與一系列額外福利相結合。補充保險計劃 E、H、I 和 J 不再提供給新參保者；擁有這些保單的人士可以維持其現有的承保範圍，但可能希望將福利與保費成本進行比較，以確定他們的計劃是否仍然具有成本效益。但是，他們應該記住，如果他們決定改用新計劃，他們將不被允許回到原來的計劃。

在 2020 年 1 月 1 日或之後新符合醫療保險資格的人士無法購買補充保險計劃 C 或 F 計劃，包括高免賠額計劃 F。

我什麼時候可以購買補充保險保單？

在紐約州，您可以在加入醫療保險後隨時購買補充保險保單。即使您未滿 65 歲並因殘疾而擁有醫療保險，您也有機會購買保單。

When can I switch Medigap policies?

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

How do I choose a Medigap policy?

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

How am I protected?

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

How are premiums determined?

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

When will my coverage start if I have a pre-existing health condition?

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

我什麼時候可以切換補充保險保單？

在紐約州，您可以隨時更換獲得補充保險保單的公司以及補充保險保單的類型。一些公司要求您在切換到他們提供的不同計劃之前保留一段時間。但是，您仍然可以從提供它的其他公司獲得所需的計劃。

如何選擇補充保險保單？

由於補充保險計劃是標準化的，您首先需要確定您需要的承保水平。一旦您確定哪一組福利適合您，您就可以比較提供適合您的計劃的保險公司的保費、服務和聲譽。大多數補充保險保險公司與醫療保險有安排，您的索賠通過電子方式從醫療保險轉發給補充保險保險公司，因此您和您的提供者無需單獨向您的補充保險計劃提交索賠。公司可以按月、按季或按年收取保費；您的偏好可能是特定的付款時間表。

我如何受到保障？

今天出售的所有標準補充保險保單都保證可續保。除非您不支付保費，或者您在申請中作出虛假陳述，否則保險公司不能拒絕續保。聯邦法律禁止保險公司或銷售人員向您出售第二份補充保險保單，該保單與您已有的保單重複，從而保護您免受購買超出您需要的保險範圍的壓力。每當您需要不同級別的承保範圍時，您都可以轉換補充保險保單。例如，當您的健康需求較大時，如果您發現 B 計劃太有限，您可以安排購買 G 計劃。新的補充保險政策將取代之前的政策。在新政策生效之前，請勿取消舊政策。

如何確定保費？

在紐約州，您受到「社區評級」的保護。保險公司為其標準補充保險保單之一設定的月度保費對於某個地理區域內的所有人士必須相同，無論其年齡、性別或健康狀況如何。有關紐約市醫療保險受益人的保險公司及其保費列表，請參見第 24 頁。

如果我已有健康狀況，我的保險何時開始？

補充保險因預先存在的健康狀況而被拒絕的最長期限是新保單的前六個月，而且只針對與該狀況直接相關的索賠。既存病症是指在保險生效日期之前的六個月內，由醫生提供的醫療建議、或接受的治療。如果(1)您在65歲首次有資格享受醫療保險時的公開註冊期間購買保單，或(2)您在以前的健康計劃中投保至少6個月，且中斷時間不超過63天，您可能資格立即獲得已有健康狀況的保險。如果您以前的健康計劃保險時間少於6個月，您的新補充保險保單必須記入您的承保月數。有些保險公司對既存病症有較短的等待期。在網上可以找到關於既存病症等待期的圖表：

www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates。

What paperwork will I receive from my Medigap insurer?

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

STANDARD MEDIGAP PLANS

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

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

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

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

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

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

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

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

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

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

我會從我的補充保險公司收到什麼文件？

補充保險公司需要向您發送一份福利說明 (EOB), 以證明其支付了您的部分索賠。EOB 與您從補充保險收到的補充保險摘要通知 (MSN) 相結合, 為您提供有關如何處理您的醫療保健索賠的所有資訊。

標準醫療保險計劃

以下是十個標準補充保險計劃(計劃 A-N)的描述, 每個計劃提供的福利:

計劃 A(基本政策)提供以下基本福利:

- 每個醫療保險福利期住院第 61-90 天的 A 部分共付額(2022 年每天 \$389)的承保範圍。
- 醫療保險的 60 個不可續期住院終生儲備日的每一天的 A 部分共付額(2022 年每天 \$778)的承保範圍。
- 在所有醫療保險醫院福利用盡後, 100% 的符合條件的醫療保險 A 部分住院費用承保。在投保人的一生中, 承保範圍僅限於最多 365 天的額外住院治療。
- 醫療保險 A 部分臨終關懷費用分攤的承保範圍。
- 醫療保險 A 部分和 B 部分的承保範圍為每個日曆年前 3 品脫血液(或等量的濃縮紅細胞)的合理費用, 除非根據聯邦法規進行更換。
- 在達到年度免賠額(2022 年為 \$233)後, B 部分服務的共同保險承保範圍(通常為醫療保險批准金額的 20%)。

計劃 B 包括基本福利, 以及

- 醫療保險 A 部分住院自付額的承保範圍(2022 年每個福利期 \$1,556)。

計劃 C¹ 包括基本福利, 以及

- 醫療保險 A 部分住院自付額的承保範圍。
- 專業護理機構護理共付額的承保範圍(2022 年每個福利期的第 21 天至第 100 天每天 \$194.50)。
- 醫療保險 B 部分免賠額的承保範圍(2022 年每個日曆年 \$233)。
- 在扣除 \$250 的自付額後, 承保 80% 的國外醫療必要緊急護理費用, 終身最高賠付額為 \$50,000。

計劃 D 包括基本福利, 以及

- 醫療保險 A 部分住院自付額的承保範圍。
- 專業護理機構護理每日共付額的承保範圍。
- 在 \$250 的免賠額和 \$50,000 的終生最高福利後, 承保 80% 的外國醫療必要緊急護理費用。

1 計劃 C、F 和 F+ 僅適用於在 2020 年 1 月 1 日之前首次符合醫療保險資格的人士。

PLAN F¹ includes the basic benefits, plus

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily coinsurance.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges, also known as limiting charge².
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible with a \$50,000 lifetime maximum benefit.

PLAN F+¹ (high deductible)

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

PLAN G includes the basic benefits, plus

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily copayment.
- Coverage for 100% of Medicare Part B excess charges, also known as limiting charge¹.
- Coverage for 80% of the cost of medically necessary emergency care in a foreign country, after a \$250 deductible, with a \$50,000 lifetime maximum benefit.

PLAN G+ (high deductible)

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

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

PLAN K³ includes the basic benefits, plus

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

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

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

計劃 F¹ 包括基本福利, 以及

- 醫療保險 A 部分住院自付額的承保範圍。
- 專業護理機構護理日常共同保險的承保範圍。
- 醫療保險 B 部分免賠額的承保範圍。
- 承保 100% 的醫療保險 B 部分超額費用, 也稱為限制費用²。
- 在 \$250 的免賠額和\$ 50,000 的終生最高福利後, 80% 的外國醫療必要緊急護理承保。

計劃 F+¹ (高免賠額)

- 與標準計劃 F 相同的福利, 但受益人必須在計劃支付任何費用之前滿足高免賠額(2022 年為 \$2,490)。這個數額每年都會增加。高免賠額保單的保費較低。

計劃 G 包括基本福利, 以及

醫療保險 A 部分住院自付額的承保範圍。

專業護理機構護理每日共付額的承保範圍。

承保 100% 的醫療保險 B 部分超額費用, 也稱為限制費用¹。

在扣除 \$250 的自付額後, 承保 80% 的國外醫療必要緊急護理費用, 終身最高賠付額為 \$50,000。

計劃 G+ (高免賠額)

- 與標準計劃 G 相同的福利, 但受益人必須在計劃支付任何費用之前滿足高免賠額(2022 年為 \$2,490)。這個數額每年都會增加。高免賠額保單的保費較低。儘管 G 計劃不涵蓋 B 部分免賠額, 但您為該免賠額支付的金額將計入 G+ 免賠額。

補充保險計劃 E、H、I 和 J 不再出售給新投保人。但是, 目前擁有 E、H、I 或 J 計劃的人士可以保留他們的保單。

計劃 K³ 包括基本福利, 以及

- 醫療保險 A 部分住院自付額的 50% 的承保範圍。
- 在您達到醫療保險 B 部分的年度免賠額後, 承保 50% 的 B 部分共同保險, 但承保 B 部分預防性服務的 100% 的共同保險。
- 在每個醫療保險福利期的住院第 61-90 天提供 100% 的 A 部分共付額。
- 為醫療保險的 60 個不可續期住院住院終生儲備日的每一天提供 100% 的 A 部分共付額。
- 在所有醫療保險醫院福利用盡後, 100% 的醫療保險 A 部分符合條件的住院費用得到承保。在投保人的一生中, 承保範圍僅限於最多 365 天的額外住院治療。

² 該計劃支付醫療保險批准的 B 部分服務金額與醫療保險或州法律規定的限制費用之間的差額。

³ 計劃 K、L 和 N 的基本收益與計劃 A-G 的類似, 但成本分攤水平不同。計劃 K 和 L 的年度自付費用限額可以每年更改。

hospital care during the policyholder's lifetime.

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

PLAN L³ includes the basic benefits, plus

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

Plan M includes the basic benefits, plus

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

Plan N³ includes the basic benefits, plus

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

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

- 50% 的臨終關懷費用分攤。
- 承保前 3 品脫血液的 50% 符合醫療保險資格的費用。
- 承保 50% 的專業護理機構護理每日共付額。
- 2022 年的年度自付費用限額為\$6,620。

計劃 L³ 包括基本福利, 以及

- 醫療保險 A 部分住院自付額的 75% 的承保範圍。
- 在您達到醫療保險 B 部分的年度免賠額後, 承保 75% 的 B 部分共同保險, 但承保 B 部分預防性服務的 100% 的共同保險。
- 在每個醫療保險福利期的住院第 61-90 天提供 100% 的 A 部分共付額。
- 為醫療保險的 60 個不可續期住院患者終生儲備日的每一天提供 100% 的 A 部分共付額承保。
- 在所有醫療保險醫院福利用盡後, 100% 的醫療保險 A 部分符合條件的住院費用得到承保。在投保人的一生中, 承保範圍僅限於最多 365 天的額外住院治療。
- 75% 的臨終關懷費用分攤。
- 承保前 3 品脫血液的 75% 符合醫療保險資格的費用。
- 涵蓋 75% 的專業護理機構護理每日共同保險。
- 2022 年的年度自付費用限額為\$3,310。

計劃 M 包括基本福利, 以及

- 醫療保險 A 部分住院自付額的 50% 的承保範圍。
- 涵蓋 100% 的專業護理機構每日共付額。
- 在扣除 \$250 的自付額後, 承保 80% 的國外醫療必要緊急護理費用, 終身最高賠付額為 \$50,000。

計劃 N³ 包括基本福利, 以及

- 承保 100% 的醫療保險 A 部分住院住院自付額。
- 承保 100% 的醫療保險 B 部分共同保險金額, 但門診就診最高 \$20 的共付額和急診室就診最高 \$50 的共付額除外。
- 涵蓋 100% 的專業護理機構每日共付額。
- 在扣除 \$250 的自付額後, 承保 80% 的國外醫療必要緊急護理費用, 終身最高賠付額為 \$50,000。

³計劃 K、L 和 N 的基本收益與計劃 A-G 的基本收益相似, 但成本分攤水平有所不同。計劃 K 和 L 的年度自付費用限額每年都會有所改變。

BENEFITS INCLUDED IN THE TEN STANDARD MEDICARE SUPPLEMENT PLANS

Basic Benefits: Included in all plans

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

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

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

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

十項標準醫療補充計劃中包含的福利

基本福利:包含在所有計劃中

- 住院治療:A 部分共付額, 醫療保險福利結束後額外 365 天的承保, 以及 60 天的終生保留天共付額承保。
- 醫療費用:B 部分共同保險(通常為 醫療保險批准費用的 20%)。
- 血液:每年的前 3 品脫血液。
- 臨終關懷:A 部分費用分攤。

A	B	C	D	F*	G*	K	L	M	N
基本福利	基本福利	基本福利	基本福利	基本福利	基本福利	基本福利**	基本福利**	基本福利**	基本福利**
		熟練護理共同保險	熟練護理共同保險	熟練護理共同保險	熟練護理共同保險	熟練護理共同保險 (50%)	熟練護理共同保險 (75%)	熟練護理共同保險	熟練護理共同保險
	A 部分免賠額	A 部分免賠額	A 部分免賠額	A 部分免賠額	A 部分免賠額	A 部分免賠額 (50%)	A 部分免賠額 (75%)	A 部分免賠額 (50%)	A 部分免賠額
		B 部分免賠額		B 部分免賠額					
				B 部分超額	B 部分超額				
		國外旅行緊急情況	國外旅行緊急情況	國外旅行緊急情況	國外旅行緊急情況			國外旅行緊急情況	國外旅行緊急情況
						自付限額 \$6,620	自付限額 \$3,310		

*計劃 F 和 計劃 G 還提供高免賠額選項。

**這些計劃涵蓋基本福利, 但有一些不同的費用分攤要求。

致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

Updated March 2022

MEDICARE SUPPLEMENT INSURANCE POLICIES

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

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

*Globe Life Insurance (formerly First United American) premiums differ by zip code. Use above link to find rates where you live.

** Only individuals who were Medicare eligible prior to January 1, 2020, can purchase Medigap Plans C, F and F+.

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

2022 年 3 月更新

醫療保險補充保險保單

請直接致電各個公司以獲取其最新的月度費率，因為它們可能會發生變化。紐約州金融服務部網站上提供了更新的費率圖表：

https://www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates .

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

*Globe Life Insurance (前身為 First United American) 的保費因郵政編碼而異。使用上面的連結查找您居住的地方的價格。

** 只有在 2020 年 1 月 1 日之前符合 醫療保險資格的個人才能購買補充保險計劃 C、F 和 F+。

致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

MEDICARE ADVANTAGE PLANS

HMO, PPO, HMO-POS, SNP

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

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

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

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

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

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

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

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

醫療保險優勢計劃 HMO、PPO、 HMO-POS、SNP

醫療保險優勢(MA) 計劃為受益人提供原始醫療保險的替代方案。醫療保險優勢計劃由私營公司提供, 包括以下類型: 健康維護組織 (HMO)、首選提供者組織 (PPO)、具有服務點選項的 HMO (HMOs-POS) 和特殊需求計劃 (SNP)。提供醫療保險優勢計劃的公司與醫療保險和醫療補助服務中心 (CMS) 簽訂合同, 為參保者提供醫療保險福利。

要符合加入醫療保險優勢計劃的資格, 您必須同時擁有醫療保險 A 部分和 B 部分, 並且居住在該計劃的服務區。醫療保險優勢計劃不能因為健康問題而拒絕申請人(或對原有疾病施加等待期)。

加入醫療保險優勢計劃是自願性的。醫療保險優勢計劃必須涵蓋醫療保險 A 部分和 B 部分所涵蓋的所有醫療必要服務, 並且通常包括額外福利, 例如處方藥以及視力、牙科和聽力服務的承保範圍。如果您希望獲得醫療保險 D 部分處方藥承保並屬於醫療保險優勢計劃, 您必須通過您的計劃獲得 D 部分藥物承保; 您不能加入單獨的 D 部分計劃。所有醫療保險受益人都有權獲得所需的醫療服務, 從醫生那裡獲得有關治療選擇的完整資訊, 並有權對醫療保險優勢計劃拒絕提供的服務或報銷提出上訴。

如果您加醫療保險優勢計劃, 則不能購買補充保險保單, 因為這會重複承保。

醫療保險優勢計劃的每位成員都必須在註冊過程中收到一份福利摘要。必須概述有關額外保費、常規程序、緊急情況下的到訪和通知要求以及服務共付額的關鍵資訊。提供者目錄、計劃中的藥房列表以及承保藥物的處方列表也可從計劃中獲得。

醫療保險優勢計劃擁有由醫生、健康中心、醫院、專業護理機構和其他護理提供者組成的網絡。這些網絡可以是本地的、全州的, 甚至是全國性的。聯繫本計劃以了解提供者網絡的範圍很重要, 尤其是當您旅行並可能需要在您居住區域以外的護理(緊急護理除外)時。

HMOs - 要求醫療保險受益人從其醫生網絡中選擇一名初級保健醫生 (PCP)。在該網絡中, 您可以選擇醫生, 前提是他或她正在接受新患者。一些 HMO 需要轉介專家服務。您必須從您的 HMO 網絡中的提供者那裡獲得您的醫療保健。除緊急護理外, 不承保從網絡外提供者處獲得的服務; 受益人將負責此類服務的全部費用。

PPOs - 擁有醫療保健提供者和醫院網絡, 但不限制參保者脫離網絡。PPO 為參保者從網絡內提供者處獲得的服務設定固定的共付額; 參保者將為網絡外提供者提供的服務支付更多費用。

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

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

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

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

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

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

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

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

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

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

(網絡外提供者需繳納醫療保險的限制費用, 這限制了他們可以向醫療保險受益人收取服務費用的金額。)

HMO/POS - 類似於 PPO 計劃。與 HMO 相比, 會員擁有更大的靈活性, 因為他們可以使用網絡內和網絡外的提供者。但是, HMO-POS 計劃可能無法涵蓋網絡外的所有福利。例如, 一個計劃可能只提供網絡內住院醫院保險。有關詳情, 請聯絡計劃。

SNPs - 是醫療保險優勢計劃, 僅適用於某些享有醫療保險的人群——例如, 同時擁有醫療保險和醫療補助的人; 患有某些慢性病的人; 以及住在養老院等機構中的人。承保醫療保險 A 部分和 B 部分以及 D 部分處方藥承保的服務。SNP 還可能涵蓋其所針對的特定人群可能需要的其他服務。

可以在美國政府的手冊 *Medicare and You* 中找到聯邦醫療保險優勢計劃列表。有關計劃的詳情, 請瀏覽 www.medicare.gov 或致電 **1-800-MEDICARE**

加入醫療保險優勢計劃(MA) 計劃: 新符合醫療保險資格的人可以在其初始註冊選擇期 (ICEP) 期間加入。

對於大多數人來說, ICEP 是他們第一次符合醫療保險資格的月份周圍的 7 個月。他們的計劃將在獲得醫療保險資格的第一個月或註冊月份的次月生效。延遲 B 部分註冊的受益人將延長其 ICEP 以允許他們在 B 部分開始之前的幾個月內註冊 MA 計劃, 這樣他們的醫療保險優勢計劃將與他們的部分在同一個月生效

B. 可通過 www.medicare.gov 網上註冊、致電 1-800-MEDICARE 或直接聯絡計劃。

在首次有資格獲得醫療保險時(在其 ICEP 期間)註冊 MA 計劃的人有一個開放註冊期, 允許他們在首次有權獲得醫療保險後三個月內切換到不同的 MA 計劃, 或更改為原始醫療保險(有或沒有 D 部分計劃)。

MA 計劃的所有受益人在年初也有一個開放註冊期, 即 1 月 1 日至 3 月 31 日。在此期間, 他們可以切換到不同的醫療保險優勢計劃或更改為原始醫療保險, 更改首先生效下個月, 2 月 1 日、3 月 1 日或 4 月 1 日。要進行此更改, 您只需加入新的醫療保險優勢計劃, 或者如果您想切換到原始醫療保險, 則加入獨立的 D 部分計劃。此註冊將自動讓您退出之前的醫療保險優勢計劃。

SEP65 - 是一個特殊註冊期, 適用於在 65 歲生日前後的初始承保選擇期 (ICEP) 期間投保 MA 計劃的因年齡(非殘疾)而符合醫療保險資格的人士。它允許他們在 MA 計劃生效後的 12 個月內切換到原始醫療保險(而不是另一個 MA 計劃)。

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

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

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

Tips for Switching Between Original Medicare and Medicare Advantage

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

Medicare Advantage Appeals

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

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

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

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

年度選擇期 (AEP): 從 10 月 15 日至 12 月 7 日, 您可以加入新的醫療保險優勢計劃(MA) 或從 MA 計劃轉換為原始醫療保險, 或從原始醫療保險轉換為 MA 計劃, 變更生效1月1日。

LIS 特殊註冊期 (SEP): 獲得額外幫助的受益人可以在一年的前九個月(1 月至 3 月; 4 月至 6 月; 7 月至 9 月)每季轉換一次計劃, 更改在下個月的第一天生效。個人可以加入新的醫療保險優勢計劃或從 MA 計劃轉換為原始醫療保險或從原始醫療保險轉換為帶有 D 部分計劃的 MA 計劃。

在原始聯邦醫療保險和聯邦醫療保險優勢計劃之間切換的提示

- ☐ 聯邦醫療保險對原始聯邦醫療保險的優勢: 選擇並加入與原始聯邦醫療保險合作的 D 部分計劃; 這將觸發您退出 MA 計劃。考慮補充保險, 例如補充保險。
- ☐ 聯邦醫療保險優勢計劃到聯邦醫療保險優勢計劃: 加入所需的聯邦醫療保險優勢計劃; 這將觸發您退出原始 MA 計劃。
- ☐ 原始聯邦醫療保險到聯邦醫療保險優勢計劃: 加入所需的聯邦醫療保險優勢計劃; 這將觸發您退出與原始聯邦醫療保險合作的 D 部分計劃。您可能希望取消您的補充保險。

醫療保險優勢計劃上訴

對您的計劃決定不提供或不支付服務費用的上訴由計劃的索賠部門處理。醫療保險優勢計劃參保者的上訴流程會有所不同, 具體取決於您是尚未接受服務、已經接受服務, 還是正在就拒絕處方藥提出上訴。注意提出上訴的時限。

醫療保險優勢計劃參保者在接受服務或項目之前被拒絕承保健康服務或項目, 可以上訴該計劃以重新考慮其決定。按照拒絕醫療保險通知中的步驟進行操作。

如果醫療保險優勢計劃拒絕承保您已經收到的健康服務或項目, 您可以選擇向您的計劃提出上訴以重新考慮其決定。按照福利說明或拒絕付款通知中的步驟進行操作。

無論您是參加原始醫療保險還是醫療保險優勢計劃的人, 拒絕處方藥承保的上訴都是一樣的。有關 D 部分的承保上訴, 請參見第 33 頁。

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

Frequently Asked Questions about Medicare Advantage Plans

What are my out-of-pocket costs in a Medicare Advantage plan?

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

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

What about emergency services?

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

How do I complain about quality of care?

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

What differences are there between obtaining services with Original Medicare vs. Medicare Advantage?

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

對於護理質素投訴，或者如果您覺得您的醫療保險 A 部分或 B 部分服務過早結束，例如您提前出院，請致電 Livanta，電話：1-877-588-1123 (TTY: 1-855-887-6668)。

關於醫療保險優勢計劃的常見問題

我在醫療保險優勢計劃中要自付多少費用？

每個醫療保險優勢計劃都有自己的保費和費用分攤。除了每月的醫療保險 B 部分保費外，您還可以直接向該計劃支付每月保費。所有費用分攤要求必須在您的福利卡或福利摘要中清楚地向您說明。如果您不確定，請致電該計劃醫療服務可能有共同支付、共同保險和免賠額。確保您了解初級保健就診、專科醫生就診、住院、處方藥和其他服務的不同自付費用。

所有醫療保險優勢計劃都必須對您在特定日曆年內為 A 部分和 B 部分承保的服務自付費用設置一個限制，稱為您的最大自付費用 (MOOP)。到 2022 年，HMO 計劃中的網絡內服務 MOOP 不能超過 \$7,550，PPO 計劃中的網絡內和網絡外綜合服務的 MOOP 不能超過 \$11,300。

緊急服務呢？

您的醫療保險優勢計劃將涵蓋緊急醫療護理，前提是您遵守通知和批准的要求。您可能需要先向服務提供者付款，然後向報銷計劃提出索賠。如果計劃確定您對護理的需求不符合其條件，或者通知有誤，它可能會拒絕支付費用。

我可以如何投訴護理質素？

如果您的投訴與您接受的醫療保健質量有關，您應該遵循您計劃的申訴程序。您還可以向位於紐約州 Livanta 的醫療保險受益人和以家庭為中心的護理質量改進組織 (BFCC-QIO) 提出您的案例，該組織的醫生和其他專業人員會審查向醫療保險患者提供的護理。可以致電 1-866-815-5440 聯絡 Livanta。

使用原始醫療保險與醫療保險優勢計劃獲得服務之間有什麼區別？

使用原始醫療保險，受益人可以從美國任何地方的任何原始聯邦醫療提供者那裡獲得醫療所需的服務。原始聯邦醫療為這些服務設定費用，並承擔大部分費用的 80%。受益人負責餘額。補充保險 (參見第 18 頁)，可以覆蓋受益人的全部或大部分費用份額。醫療保險優勢計劃是管理式醫療計劃，運作方式不同。他們有自己的成本結構，包括保費、免賠額、共付額和最高自付費用。

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

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

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

Will I need a Medicare supplement insurance policy?

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

我應該如何決定是否加入醫療保險優勢計劃以及哪個計劃可能適合我？

在加入計劃之前，您應該考慮以下事項：您目前的醫生參與計劃；醫院參與計劃；該計劃的處方藥承保範圍；其成本；及其地理服務區域。緊記要在每年在年度選擇期間（10 月 15 日至 12 月 7 日）審查此資訊。

1. 您的醫生參與計劃：詢問您的醫生他們參與了哪些計劃，以及他們是否根據該計劃接受新的醫療保險患者。即使您已經與特定醫生建立了關係，您也需要確定他們會根據該計劃接受您作為新患者。每年確認提供者參與。
2. 醫院參與計劃：確保您使用的任何醫院以及您希望到訪的任何醫院都參與該計劃，或者允許您在網絡外瀏覽它們。
3. 處方藥承保：使用 Medicare.gov 計劃瀏覽器（參見第 32 頁）查看計劃如何承保您的處方藥（處方、限制、費用）。
4. 費用：通過醫療保險優勢計劃接受護理的費用可能低於通過原始醫療保險接受護理的費用。醫療保險優勢計劃還可能涵蓋原始醫療保險未涵蓋的服務，例如常規視力和牙科護理以及助聽器。在註冊前研究醫療保險優勢計劃的費用結構（保費、共付額、免賠額、最大自付費用等）。
5. 地理服務區域：HMO 計劃定義了他們服務的地理區域，但還必須涵蓋其服務區域之外的緊急護理。如果您希望在 HMO 的服務區域之外停留任何時間，請檢查它是否會覆蓋您那裡。PPO 和 HMO-POS 計劃的服務領域限制較少，但您仍應了解它們是什麼。
6. 星級評分：每個計劃都有根據醫療保險衡量標準的星級（質量）評分。

我需要醫療保險補充保險嗎？

如果您加入醫療保險優勢計劃，您將不需要聯邦醫療補充保險，因為補充保險僅適用於原始醫療保險。如果您決定加入醫療保險優勢計劃，並且您已經擁有補充保險保單，您可能希望暫時保留它，同時確定醫療保險優勢計劃是否令人滿意。根據紐約州法律，如果您退出醫療保險優勢計劃並返回原始醫療保險，您將可以購買補充保險保單，但如果您在當前健康狀況存在差距，您可能會面臨一段不承保期。有關補充保險的詳情，請參見第 18 頁。

MEDICARE PART D – PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

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

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

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

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

醫療保險 D 部分 – 處方藥承保範圍

醫療保險 D 部分是通過私人保險公司提供的保險，以幫助受益人支付處方藥費用。

醫療保險處方藥計劃適用於所有擁有醫療保險的人(A 部分和/或 B 部分)。D 部分是一項可選和自願的福利；醫療保險受益人不需要加入計劃，但延遲加入可能會受到處罰。

醫療保險 D 部分是通過與聯邦政府簽訂合同為 醫療保險受益人提供 醫療保險 D 部分藥物承保的私營公司提供的。醫療保險和醫療補助服務中心 (CMS) 負責管理承保藥物的計劃和類別。每個 D 部分計劃都有自己的承保藥物清單(處方集)和參與藥房，以及受益人必須遵循的程序才能獲得新藥或藥物的承保，他們需要滿足他們的特殊需求。

您可以通過以下兩種方式之一獲得醫療保險 D 部分承保：

1. 通過獨立處方藥計劃 (PDP): PDP 與原始醫療保險合作，並且僅承保處方藥。
2. 通過具有處方藥保險 (MA-PD) 的醫療保險優勢計劃: 這些是管理式醫療計劃，例如 HMO、PPO、HMO-POS 或 SNP，提供涵蓋以下所有方面的綜合福利包: 醫院、醫生、專科醫生、藥房和處方。如果您參加醫療保險優勢計劃並希望獲得 D 部分承保，則必須通過您的醫療保險優勢計劃獲得。

那些選擇加入 D 部分計劃的人將必須支付每月保費並支付部分處方費用。藥物計劃在承保的處方藥(處方)、您必須支付的金額(保費、免賠額、共付額)以及您可以使用的藥房(網絡)方面有所不同。所有藥物計劃必須至少提供醫療保險設定的標準承保範圍。但是，一些計劃提供增強的福利，並可能收取更高的每月保費。當您加入藥物計劃時，選擇滿足您的處方藥需求的藥物非常重要。

收入較高的受益人(2022 年個人超過 \$91,000 或一對夫婦超過 \$182,000)將在其計劃保費之外支付 D 部分的附加費。2022 年的附加費從每月 \$12.40 到 \$77.90 不等，支付方式與 B 部分保費相同，通常是從受益人的社會保障支票中扣除(參見第 56 頁的費率表)。

儘管 D 部分計劃的福利設計各不相同，但它們都包括 2022 年的以下內容：

- 免賠額(2022 年最高為**\$480**)。在您的計劃幫助支付您的藥物費用之前，這是您必須自付費用的金額。有些計劃的免賠額較低或沒有。
- 初始覆蓋級別。您支付最高 25% 的藥物費用的固定共付額，最高藥物費用總額為 \$4,430 (2022 年)。(總藥物費用包括您支付的金額和計劃為您的藥物支付的金額。
- 覆蓋差距。在您的總藥費達到 \$4430(2022年)後，您通常要支付品牌藥和非專利藥費用的25%(加上象徵性的藥房配藥費)，直到您的 True Out-of-Pocket (TrOOP)達到 \$7050 (2022 年)。

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

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

Enrollment in Medicare Part D

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

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

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

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

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

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

這包括免賠額(如果有的話)加上在達到覆蓋差距之前支付的任何共付額或共同保險, 在覆蓋差距中購買的品牌藥物的大部分費用, 以及在覆蓋差距中購買的非專利藥物的自費費用。

- 災難性覆蓋。在您支付 \$7,050 的 TrOOP 後(2022 年), 您支付 5% 的藥物費用或固定共付額 \$3.95 的仿製藥和 \$9.85 的品牌藥(2022 年), 以較大者為準。

加入醫療保險 D 部分

加入醫療保險處方藥承保涉及選擇與原始醫療保險合作的 D 部分計劃 (PDP), 或與處方藥承保 (MA-PD) 合作的醫療保險優勢計劃。您可以在 www.medicare.gov 或致電 1-800-MEDICARE 比較計劃。您也可以聯絡 HIICAP 尋求幫助。

您可以在七個月的初始註冊期 (IEP) 期間註冊 D 部分(請參閱第 6 頁)。此外, 您可以在每年 10 月 15 日至 12 月 7 日期間的年度選舉期 (AEP) 期間加入或更改計劃一次, 從 1 月 1 日起生效。

在有限的情況下, 受益人也可能有權在特殊註冊期 (SEP) 中投保 D 部分計劃或在 AEP 之外轉換計劃。這些包括以下情況:

- 有額外幫助/LIS 的個人可以在一年的前九個月(1 月至 3 月;4 月至 6 月;7 月至 9 月)每個日曆季度轉換一次計劃, 更改在下個月的第一天生效。
- 除了 AEP 之外, EPIC 成員每個日曆年可以更改一次 D 部分計劃(參見第 35 頁)。
- 在 1 月 1 日至 3 月 31 日期間, 參加醫療保險優勢計劃(有或沒有 D 部分)的個人可以更改為不同的醫療保險優勢計劃(有或沒有 D 部分), 或更改為有或沒有 D 部分藥物承保的原始醫療保險。
- 永久改變居住地的個人, 包括搬到另一個有新的 D 部分計劃選擇的縣的人、在國外居住後返回美國的人和從監獄釋放的人, 可以參加 D 部分計劃或轉換計劃。
- 搬入、目前居住或離開長期護理機構(包括專業護理機構)的個人可以參加 D 部分計劃或轉換計劃。
- 退出僱主/工會贊助的保險(包括 COBRA)的個人可以加入 D 部分計劃。
- 參加處方藥計劃且退出其服務區域的個人可以切換到新的計劃。

您可以通過多種方式申請加入醫療保險 D 部分計劃:

- 瀏覽 www.medicare.gov 或計劃網站。
- 致電 1-800-MEDICARE 或直接致電計劃。
- 當面, 通過 D 部分計劃的代表, 在預定的家訪期間。

Late Enrollment Penalty

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

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

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

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

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

How do I select a Part D plan?

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

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

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

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

逾期註冊罰款

- 即使是目前不使用大量處方藥的醫療保險受益人也應考慮購買 D 部分計劃。如果他們沒有可靠的藥物承保(承保範圍至少與標準的醫療保險處方藥承保範圍一樣好)，如果他們選擇延遲投保，他們將不得不支付延遲投保罰款。罰款相當於「國家基本受益人保費」的 1%(2022 年為 \$33.37)，因為這些受益人沒有參加 Medicare 處方藥計劃且沒有可計入的承保範圍，因此這些受益人首次符合條件後的每個整月都會受到 1% 的罰款。只要他們有 D 部分保險，他們就必須支付這筆罰款。如果他們有可靠的承保，並且承保結束與醫療保險 D 部分承保開始之間的差距不超過 63 天，他們將不會受到處罰。獲得全部或部分額外幫助的人沒有延遲註冊罰款(參見第 33 頁)。
- 那些在初始註冊期間 (IEP) 註冊 D 部分的人不會受到延遲註冊罰款。擁有可靠保險的人也不會，例如通過前僱主或工會、退伍軍人管理局 (VA) 或軍人醫療保險。

如果我有僱主健康保險，我是否需要 D 部分計劃？

如果您通過現任或前任僱主擁有可靠的藥物承保(藥物承保至少與標準 D 部分藥物福利一樣好)，您可能不需要加入 D 部分計劃。現任或前任僱主應以書面形式告知您您的藥物承保範圍是否「可信」。如果它是可靠的藥物保險，您可能不想同時加入 D 部分計劃，因為這可能會危及您的僱主/退休人員藥物保險，甚至其他退休人員福利。如果您沒有收到信函，請聯絡僱主以確定您是否應該參加 D 部分計劃。

如果我不服用任何藥物，我是否需要 D 部分計劃？

擁有 D 部分保險是可選的，但請記住，藥物需求可能會發生變化，如果您的需求發生變化，除非您有資格享受特殊投保期，否則您將需要等到 10 月 15 日至 12 月的年度選擇期 (AEP) 7 簽署將於明年 1 月生效的計劃。此外，如果您在首次符合條件時未註冊，您可能會面臨延遲註冊處罰。考慮到所有這些，您可能想要註冊最便宜的計劃。

如何選擇 D 部分計劃？

要選擇 D 部分計劃，最好使用 www.medicare.gov 上的計劃瀏覽工具。您可以使用您的醫療保險帳戶用戶名和密碼登入，或者在不輸入識別資料的情況下進行一般搜索。

按照計劃瀏覽器提示正確輸入您當前正在服用或預計在來年服用的所有藥物，以及所需的劑量和數量。在您開始此過程之前，最好從您的藥劑師那裡獲得您的藥物清單。

您可以選擇多個您希望包含在搜索中的藥房。輸入所有資料後，計劃瀏覽器將允許您選擇要查看的計劃類型 - 與原始醫療保險一起使用的 D 部分計劃或醫療保險優勢計劃。您可以使用各種工具來過濾搜索結果。查看每個計劃的詳情以了解可能適用的限制（如果有）非常重要。還建議致電計劃提供者以驗證資料。

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

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

Cost Utilization Management Tools

To control costs, Medicare prescription drug plans employ cost utilization management tools—Tiers, Prior Authorization, Step Therapy, Quantity Limits.

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

Part D Appeals

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

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

Extra Help with Drug Plan Costs for People with Limited Incomes

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

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

當您選擇了適合您的計劃後，您可以網上註冊或致電醫療保險 (1-800-MEDICARE) 或 D 部分計劃提供者。HIICAP 顧問能夠幫助您使用計劃瀏覽器。

成本利用管理工具 為了控制成本，醫療保險處方藥計劃採用成本利用管理工具：等級、事先授權、分步治療、數量限制。

- 等級：D 部分計劃將其處方集（承保藥物清單）劃分為稱為「等級」，並為不同等級分配不同的共付額或共同保險。一般來說，仿製藥被分配到較低的等級，並且成本低於較高等級所涵蓋的品牌藥。一些計劃甚至可能免除較低級別仿製藥的免賠額。通過這種方式，他們鼓勵使用分配給較低級別的藥物。
- 事先授權：在某些情況下，在其處方中涵蓋藥物之前，計劃可能會要求醫生與其聯繫以解釋該藥物的醫療必要性。
- 分步治療：在支付昂貴的品牌藥物之前，D 部分計劃可能要求受益人嘗試用於治療相同疾病的較便宜的藥物。如果他們已經嘗試過較便宜的藥物，受益人應該與他們的醫生談談，要求他們從該計劃中獲得例外。
- 數量限制：出於安全和成本原因，計劃可能會限制其在特定時期內承保的藥物數量。例如，一個計劃可能僅涵蓋每月最多 30 天的藥物供應。

D 部分上訴

無論您是通過獨立的 D 部分計劃(PDP) 還是醫療保險優勢計劃(MA) 承保，D 部分上訴的流程都是相同的。如果您認為您需要某項計劃不承保某種藥物，或者如果該計劃將承保該藥物，但在較低級別的同病症的藥物不那麼有效時分擔較高級別的費用，您可以：

與您的開藥者談談，看看您是否可以使用另一種藥物來治療您的病情，該計劃將承保（或將在較低級別承保）。

要求計劃授予「例外」以支付您的藥物費用，或以較低的費用分攤費用支付您的藥物費用。

按照計劃拒絕通知上的指示提出上訴。注意提出上訴的時限。

為收入有限的人提供藥物計劃費用的額外幫助

聯邦政府為收入較低且資源有限的醫療保險受益人提供 D 部分計劃的費用補貼。補貼直接支付給 D 部分計劃。該援助通過低收入補貼計劃 (LIS) 提供，也稱為額外幫助，由社會保障局 (SSA) 管理。參加醫療補助和/或醫療保險儲蓄計劃 (MSP) 的人會自動獲得全面額外幫助。您也可以直接通過 SSA 申請額外幫助。

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

Benefits of Full Extra Help:

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

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

Benefits of Partial Extra Help:

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

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

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

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

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

全面額外幫助適用於月收入高達聯邦貧困線 135% 且資源限制在下述限制範圍內的受益人。收入限制包括每月額外 \$20 的收入不計。資源包括個人額外的 \$1,500 和夫婦的 \$3,000 的葬禮或殮葬費用。

全面額外幫助的福利：

- 如果選擇的計劃是「基本」計劃，則 D 部分計劃沒有月度保費，基本計劃的月度保費（2022 年高達 \$42.43）由 Extra Help 全額補貼。
- 沒有免賠額。
- 減少共同支付，取決於收入。收入高達聯邦貧困線 100% 的受益人將獲得 \$1.35（2022 年）的仿製藥和 \$4.00（2022 年）的品牌處方的共同支付。所有其他獲得全面額外幫助的人的共付額限制為仿製藥 \$3.95（2022 年）和品牌處方藥 \$9.85（2022 年）。

部分額外幫助適用於月收入高達聯邦貧困線 150% 且資源在下述限制範圍內的受益人。收入限制包括每月額外 \$20 的收入不計。資源金額包括個人額外的 \$1,500 和夫婦的葬禮或殮葬費用 \$3,000。

部分額外幫助的福利：

- 每月計劃保費根據收入按比例計算。
- 免賠額減少到不超過 \$99.00（2022 年）。
- 減少共付額：藥物成本的 15% 和計劃的成本分攤中的較低者。

額外幫助收入和資產限額（2022 年）				
	個人		夫婦	
	月收入	資產	月收入	資產
全面額外幫助	\$1,549	\$9,900	\$2,080	\$15,600
部分額外幫助	\$1,719	\$15,510	\$2,309	\$30,950

HIICAP 顧問可以幫助篩選額外幫助的資格，社會保障局也可以。要申請額外幫助，請致電 SSA 電話 1-800-772-1213 (1-800-325-0778 TTY)，或瀏覽 www.socialsecurity.gov 網上申請。您可以在一年中的任何時候申請額外幫助。

獲得額外幫助的個人在 D 部分中不會受到延遲註冊罰款。獲得額外幫助的人也可以在年度選擇期 (AEP) 之外的一年內更改他們的 D 部分計劃。有關詳情，請參見第 31 頁。

有些自動獲得額外幫助資格的人可能尚未加入 D 部分計劃。由 Humana 管理的有限收入新合格過渡 (LINET) 計劃在他們參加 D 部分計劃時為他們提供臨時(或追溯)處方藥保險。他們可能需要證明他們有資格獲得額外幫助的最佳可用證據 (BAE) 文件，例如 Medicaid 獎勵信、MSP 獎勵信或 SSI 證明。LINET 的聯絡電話是 1-800-783-1307。

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

NEWYORK STATE EPIC PROGRAM (Elderly Pharmaceutical Insurance Coverage)

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

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

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

EPIC Fee AND Deductible PLANS

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

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

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

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

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

紐約州 EPIC 計劃 (長者醫藥保險)

長者藥物保險計劃 (EPIC) 是紐約州針對長者的處方藥保險計劃。如果您年滿 65 歲, 居住在紐約州, 並且單身收入不超過 \$75,000 / 夫婦收入不超過 \$100,000, 您可能有資格獲得 EPIC。紐約州的大多數藥店都參與了 EPIC 計劃。

您必須擁有 D 部分承保範圍(PDP 或 MA-PD)才能擁有 EPIC, 但如果您還沒有 D 部分並加入 EPIC, 您可以在那時選擇 D 部分計劃。擁有全額醫療補助的個人沒有資格獲得 EPIC(那些擁有醫療補助支出的人可能仍然有資格)。

EPIC 作為醫療保險D 部分的次要保險, 以降低藥物成本。EPIC 會員每次配藥時都應在藥房出示其 D 部分卡和 EPIC 卡。在滿足 D 部分免賠額後, EPIC 提供二次保險。EPIC 還涵蓋批准的 D 部分排除藥物, 包括處方維生素和咳嗽和感冒藥。

EPIC 費用和免賠額計劃

EPIC 中有兩個計劃, 費用計劃和免賠額計劃。申請人無法選擇加入哪個計劃; EPIC 根據個人/夫婦的收入做出此決定。

EPIC 的收費計劃:適用於年收入不超過 \$20,000 的個人和年收入不超過 \$26,000 的夫婦。要參加費用計劃, 參與者需要支付年費, 費用根據他們上一年的收入按比例計算。費用按季度計費。(EPIC 為獲得全面額外幫助的會員免除費用。)

支付費用後, 參與者根據其 D 部分計劃的費用分攤, 為他們的藥物支付 EPIC 共付額(從 \$3 到 \$20 不等)。

EPIC 還為費用計劃會員支付 D 部分每月保費, 到 2022 年每月最高 \$42.43 。

EPIC 的免賠額計劃 -適用於年收入在 \$20,001 至 \$75,000 之間的人士, 以及年收入在 \$26,001 至 \$100,000 之間的夫婦。免賠額計劃的參與者支付他們的處方, 直到他們達到他們的 EPIC 免賠額, 這是根據他們上一年的收入。達到免賠額後, 參與者只需支付 EPIC 共付額。加入免賠額計劃不收取任何費用。

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

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

TIPS

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

How does EPIC work with Medicare Part D?

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

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

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

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

EPIC and Extra Help

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

EPIC 為單身收入不超過 \$23,000 / 已婚收入不超過 \$29,000 的自付額計劃成員支付 D 部分月度保費 (2022 年每月高達 \$42.43)。收入較高的自付額計劃成員必須支付自己的 D 部分保費, 但他們的 EPIC 免賠額將因基本 D 部分計劃的年度費用而降低 (2022 年為 \$510)。

自付額計劃成員滿足其自付額後, 他們只需支付 EPIC 承保藥物的共付額, 基於其 D 部分計劃的共付額。在 D 部分免賠額階段產生的藥品費用不適用於 EPIC 免賠額。

提示

- ✓ 沒有額外幫助的 EPIC 成員可能希望研究具有較低或沒有自付額的 D 部分計劃, 因為 EPIC 不承保在 D 部分計劃的自付額期間購買的處方藥。
- ✓ EPIC 註冊和 EPIC 共付額未反映在 www.medicare.gov 計劃瀏覽器工具中。

EPIC 如何與醫療保險 D 部分配合使用?

紐約法律要求 EPIC 成員也必須參加醫療保險 D 部分計劃 (參見醫療保險 D 部分, 第 30 頁), 因此任何因任何原因無法參加 D 部分的人都沒有資格參加 EPIC。

您可以在一年中的任何時間註冊 EPIC。如果您在 EPIC 註冊時沒有 D 部分計劃, 您可以在之後註冊 D 部分計劃。

D 部分的覆蓋範圍是主要的, 而 EPIC 覆蓋範圍始終是次要的。EPIC 共付額基於參保人的 D 部分計劃支付後的剩餘金額, 從而降低參保人的成本。例如, 如果您有責任為使用您的 D 部分承保的藥物支付 \$20 的共付額並擁有 EPIC, 那麼您將為 \$20 的藥物支付 EPIC 共付額, 即 \$7。EPIC 將在您達到 D 部分自付額後為您承保, 包括在初始承保級別、承保缺口期間和災難性承保期間 (如果藥物首先由您的 D 部分計劃承保)。EPIC 將成為使用 EPIC 參與藥店的 D 部分計劃成員的第二付款人, 包括紐約州的大多數零售藥店和一些郵購藥店。

EPIC 是紐約州的州藥物援助計劃 (SPAP)。SPAP 成員有一個特殊註冊期 (SEP), 允許參與者每年另外一次投保或轉換 D 部分計劃 (具有 D 部分承保範圍的醫療保險優勢計劃計劃, 或與原始醫療保險一起使用的 D 部分計劃) 到 AEP。

EPIC 和額外幫助

EPIC 要求看起來有資格獲得額外幫助的成員提供有關其當前收入和資產/資源的額外資訊, 以便 EPIC 可以代表他們向社會保障局申請額外幫助。額外幫助申請隨後將被轉發到紐約州的醫療補助計劃, 以評估是否有資格參加醫療保險儲蓄計劃 (參見第 38 頁), 以幫助支付他們的醫療保險 B 部分保費。

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

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

EPIC and Employer/Retiree Drug Coverage

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

Applying for EPIC

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

醫療保險 D 部分和 EPIC 承保的藥物的共付額：

處方費用 (提交醫療保險 D 部分計劃後)	EPIC 共付額
少於 \$ 15	\$ 3
\$ 15.01 - \$ 35	\$ 7
\$ 35.01 - \$ 55	\$ 15
多於 \$ 55	\$ 20

EPIC 和僱主/退休人員藥物保險

EPIC 要求參加 D 部分計劃；擁有僱主/退休人員藥物保險的個人不太可能擁有 EPIC，因為參加 D 部分計劃很可能會影響他們的僱主/退休人員保險。但是，有時僱主/退休人員的藥物保險被視為 D 部分計劃，在這種情況下，個人也可能擁有 EPIC。請諮詢福利經理，了解您擁有的藥物承保範圍。

申請 EPIC

- 致電 EPIC 1-800-332-3742 (TTY: 1-800-290-9138) 要求申請。
- 瀏覽 https://www.health.ny.gov/health_care/epic/ 以了解更多有關 EPIC 的詳情，您還可以提交網上要求，讓 EPIC 向您郵寄申請。
- 此連結提供可填寫的 EPIC 應用程式。仍須打印。簽名並傳真或郵寄給 EPIC 處理，
<https://www.health.ny.gov/forms/doh-5080-fillin.pdf>
- 將完成的 EPIC 申請傳真至 518-452-3576，或郵寄至 EPIC, P.O. Box 15018, Albany, NY 12212-5018。

MEDICARE SAVINGS PROGRAMS

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

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

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

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

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

醫療保險儲蓄計劃

醫療保險儲蓄計劃 (MSP) 可以幫助符合條件的個人支付其醫療保險保費和其他與醫療保險相關的費用。在紐約市, MSP 由人力資源管理局(HRA) 管理。您可以在一年中的任何時間申請 MSP。MSP 的授權期限為 12 個月; HRA 每年郵寄更新包以評估持續的資格。

以下是對不同醫療保險儲蓄計劃的描述, 隨後是其收入限制以及如何申請。

- 合格的醫療保險受益人計劃 (**QMB**): 該計劃可以支付醫療保險 A 部分和/或 B 部分的保費, 並取消 A 部分和 B 部分共同保險和免賠額。個人可以僅符合 QMB 或 QMB 以及醫療補助。
 - QMB 狀態在醫療保險摘要通知中註明, 明確指出 QMB 受益人不對任何醫療保險費用分攤負責。
 - SSI 接受者在符合醫療保險資格時, 應自動加入 QMB 以及醫療保險 A 部分和 B 部分。
- 指定低收入醫療保險受益人計劃 (**SLMB**): 該計劃支付醫療保險 B 部分保費。個人只能獲得 SLMB, 或者 SLMB 和醫療補助(有支出)。申請人必須擁有醫療保險 A 部分才有資格獲得 SLMB。
- 合格個人 (**QI**): 該計劃支付醫療保險 B 部分保費。個人不能同時接受 QI 和醫療補助。申請人必須擁有醫療保險 A 部分才有資格獲得 QI。

2022 年醫療保險儲蓄計劃	月收入	
	個人	夫婦
QMB - 合格的醫療保險受益人 紐約州為自動符合 A 部分資格的人支付保費、免賠額和共同保險。	\$1,153	\$1,546
SLMB - 指定的低收入醫療保險受益人水平 州政府僅支付醫療保險 B 部分保費。	\$1,379	\$1,851
QI - 合格個人 州政府僅支付醫療保險 B 部分保費。	\$1,549	\$2,080

注意: 上面列出的金額包括標準的 \$20 收入不計。

Applying for a Medicare Savings Program

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

What application do I use?

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

What counts as income when applying for an MSP?

- Income includes wages from an employer or self-employment. It also includes funds that are received monthly, such as Social Security, pension, veteran's benefits, unemployment insurance, etc., as well as regular distributions from an IRA, 401K, 403B, or other retirement account.
- There are certain income disregards that can reduce the amount of money that is counted when determining MSP eligibility. These include paid health insurance premiums, for example: premiums for Medigap, Long Term Care Insurance, retiree health insurance, and dental or vision insurance plans.

Note: The MSP program requires that you be collecting any Social Security benefits for which you are eligible unless you are delaying Social Security because you are working full time. (This requirement has been temporarily suspended during the Public Health Emergency).

Medicare Savings Program advocacy tips:

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

申請醫療保險儲蓄計劃

- 您可以通過協助登記者、委託代理人、當地醫療補助辦公室或郵寄/傳真申請 MSP。
 - 瀏覽 <https://www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf> 或致電 347-396-4705 查找可協助您完成申請的協助登記人。
 - 委託代理人將協助您完成申請並收集必要的證明文件。要與 HIICAP 代理顧問預約，請致電 Aging Connect 電話 212-AGING-NYC (212-244-6469) 並詢問 HIICAP。您也可以致電 1-800-333-4114 聯繫醫療保險權利中心。
 - 將填妥的申請表和證明文件副本郵寄至：醫療援助計劃；MSP-CREP, 5th Floor; P.O. Box 24330; Brooklyn, NY 11202-9801, 或在突發公共衛生事件 (PHE) 期間，您也可以將您的申請傳真至：917-639-0732。

我使用什麼應用程式？

- 如果您僅申請 MSP (不是醫療補助和 MSP)，您可以使用簡化的醫療保險儲蓄申請 DOH-4328，可在以下網址下載 <https://www.health.ny.gov/forms/doh-4328.pdf>。
- 如果您同時申請 MSP 和醫療補助，您必須使用醫療保險儲蓄申請和 Access NY Health Care 申請，DOH-4220，網址為 <https://www.health.ny.gov/forms/doh-4220.pdf>。

申請 MSP 時，什麼算作收入？

- 收入包括來自僱主或自僱人士的工資。它還包括每月收到的資金，例如社會保障、養老金、退伍軍人福利、失業保險等，以及來自 IRA、401K、403B 或其他退休帳戶的定期分配。
- 在確定 MSP 資格時，某些收入忽略可能會減少計算的金額。這些包括支付的健康保險費，例如：補充保險、長期護理保險、退休人員健康保險以及牙科或視力保險計劃的保費。
- 注意：MSP 計劃要求您領取您有資格獲得的任何社會保障福利，除非您因為全職工作而延遲社會保障。（在突發公共衛生事件期間，此要求已暫時中止）。

醫療保險儲蓄計劃宣傳提示：

- 參加 MSP 的人士自動有資格獲得全部的額外幫助，以降低他們的醫療保險 D 部分藥品費用（見第 33 頁）。
- 如果您通過社會安全局申請額外幫助，社會安全局將把您的資料轉給紐約州，以便考慮您的 MSP 資格。
- 即使您仍然在工作，您可能也有資格參加醫療保險儲蓄計劃，因為有賺取收入的豁免權。少於一半的工作收入會被計入 MSP 資格。

MEDICARE FRAUD AND ABUSE

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

What is 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 a different date.
- Billing for non-covered services, such as dental care, routine foot care, hearing services, routine eye exams, etc. and disguising them as covered services.
- Billing both Medicare and another insurer, or Medicare and the patient, in a deliberate attempt to receive payment twice.

What is abuse?

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

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

Medicare do's and don'ts

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

醫療保險欺詐和濫用

聯邦政府估計，數十億美元：約佔醫療保險支出的 10%，因欺詐、浪費和濫用而損失。鼓勵醫療保險受益人警惕並報告任何可疑的賬單費用。

什麼是欺詐？

欺詐是通過欺詐手段獲得或試圖獲得服務或付款的行為，故意、自願並完全了解您的行為。欺詐的例子有：

- 回扣、賄賂或回扣。
- 使用他人的醫療保險卡或號碼獲取服務。
- 為未實際提供的項目或服務開具賬單。
- 在同一日期或不同日期為同一服務計費兩次。
- 對非承保服務（例如牙科護理、常規足部護理、聽力服務、常規眼科檢查等）進行計費，並將其偽裝成承保服務。
- 故意向醫療保險和另一家保險公司或醫療保險和患者計費，故意收取兩次付款。

什麼是濫用？

濫用可能是雖然不是欺詐性的事件和做法，但可能會導致醫療保險計劃的損失。濫用的例子是：

- 過度使用醫療和保健服務。
- 不正確的計費做法。
- 增加醫療保險受益人的費用，但不增加其他患者的費用。
- 發現錯誤時不調整帳戶。
- 定期免除醫療保險 B 部分免賠額和 20% 的共同保險。

醫療保險的注意事項

- 切勿將您的醫療保險號碼提供給您不認識的人。如果您認為有人竊取了您的醫療保險受益人標識符 (MBI)，請向 Medicare 提交報告。
- 謹防使用不請自來的電話或上門拉票向您推銷商品和服務的私人健康計劃、醫生和供應商。
- 對打電話並表明自己來自醫療保險的人保持懷疑。醫療保險不會打電話給受益人，也不上門拜訪。
- 小心那些提供免費贈品以換取您的醫療保險號碼的公司。
- 注意提供非醫療運輸或家政服務作為醫療保險批准的服務的家庭醫療保健提供者。
- 懷疑那些聲稱知道如何讓醫療保險支付未承保的服務的人。
- 通過將醫療保險摘要通知 (MSN) 和其他保險的通知與實際護理進行比較，記錄您的醫生就診和賬單處理。

Be alert to:

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

How to report Medicare fraud

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

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

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

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

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

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

IDENTITY THEFT

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

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

注意：

- 重複支付相同的服務。
- 您不記得接受過的服務。
- 與收到的服務不同的服務計費。
- 您已向提供者支付的服務的醫療保險付款。

如何報告醫療保險欺詐

如果您認為存在醫療保健欺詐或濫用行為，請致電 1-800-333-4374。盡量提供以下資訊：

- 提供者或公司名稱以及其姓名旁邊的任何識別號碼。
- 您的姓名、地址和電話號碼。
- 服務日期。
- 聲稱的服務或項目類型。
- 醫療保險批准和支付的金額。
- 醫療保險摘要通知 (MSN) 的日期。
- 簡要說明問題。盡量具體說明。

當您協助醫療保險計劃揭露欺詐或濫用行為時，您就是在為醫療保險和您自己節省金錢。

要報告醫療保險欺詐和濫用

請致電 1-800-333-4374 聯絡 SMP (高級醫療保險巡邏隊)。

要報告醫療保險 D 部分計劃欺詐和濫用，請致電 醫療保險藥物完整性承辦商 (MEDIC)，電話 1-877-7SafeRx/1-877-772-3379。

**欺詐和濫用是每個人的問題
每個人都可以提供幫助！**

身份盜竊

聯邦貿易委員會提供有關如何保護您的身份資料。請聯絡 FTC 獲取資訊或致電 1-877-438-4338 或瀏覽 www.consumer.gov/scams 以作出投訴。

請保護您的醫療保險號碼和社會安全號碼，以及您的出生日期，以及任何其他個人資料，例如銀行或信用卡資料。謹慎地向那些要求您提供這些資料的人提問，並毫不猶豫地詢問他們需要這些資料的合法性。成為知情和主動的消費者。

致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

MEDICAID ELIGIBILITY FOR 65+, BLIND, OR DISABLED

Non-MAGI Medicaid

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

MEDICAID COVERS

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

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

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

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

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

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

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

65 歲以上、盲人或殘疾人的醫療補助資格

非 MAGI 醫療補助

醫療補助是一項針對低收入個人的聯邦、州和市政府聯合健康保險計劃。醫療補助是一項「入息審查」計劃，要求申請人證明符合條件的經濟需要。被確定為符合醫療補助資格的個人將獲得一張永久膠醫療補助卡，如果他們仍然符合資格，則該卡有效。除了財務指南外，醫療補助還要求申請人是美國公民或合格的外國人。在紐約市申請醫療補助的人士必須居住在紐約市。

醫療補助涵蓋

- 急診和醫院服務
- 預防服務
- 個人護理服務
- 案例管理服務
- 批准的處方藥
- 物理治療
- 言語和聽力康復
- 結核病 (TB) 相關服務
- 心理健康服務
- 私人值班護理
- 助聽器
- 診斷服務
- 職業服務
- 診所服務
- 篩查服務
- 康復服務
- 臨終關懷
- 眼鏡和驗光服務
- 牙科服務和假牙
- 假肢裝置
- 交通
- 家庭保健

您申請醫療補助的地點和方式取決於您的「類別」：65 歲以上、盲人或殘疾人通過紐約市人力資源管理局 (HRA) 申請；65 歲以下且非盲人或殘疾人的人通過紐約州衛生局 (NYSoH) 申請。本節討論 65 歲以上、盲人或殘疾人如何申請醫療補助。有關 65 歲以下且非盲人或殘疾者的醫療補助計劃的資訊，請參見第 47 頁。

65 歲以上的個人、盲人或殘疾人可以通過不同方式獲得醫療補助，具體取決於他們要求的服務。

- 社區醫療補助是居住在自己家中的人們使用的健康保險。
- 機構醫療補助提供全方位的健康保險，並為全職居民支付養老院的護理費用。（這與專業護理機構中的護理不同，後者是臨時的，由醫療保險 A 部分承保。）

社區醫療保險 - 資格要求包括 2022 年單身人士的最高月收入為 \$934 / 夫婦的最高月收入為 \$1,367，單身人士的資產限額為 \$16,800（加上 \$1,500 的殮葬基金）/\$24,600（加上 \$3,000 的殮葬基金）夫婦。

醫療補助計算所有來源的收入，包括工資、社會保障和養老金支付。有某些允許的收入扣除額，因此即使您的收入超過這些金額，我們也鼓勵您申請。此外，如果您的收入超過這些金額，您可能也有資格參加醫療補助的超額收入計劃，也稱為醫療補助抵降保費計劃。

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

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

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

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

Where do I submit the application?

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

Contact a Facilitated Enroller near you for assistance. Call 347-396-4705 or check www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf for a listing of enrollers.

Go to your local Medicaid office. You can get help with completing the application in person at the office or drop off a completed application. To find Medicaid offices near you, see page 55, call 311 and ask for the Human Resources Administration, or visit www1.nyc.gov/site/hra/locations/medicaid-locations.page.

Submit an application by mail. Mail the completed application along with supporting documents to:

Initial Eligibility Unit
HRA/Medical Assistance Program
PO Box 24390 Brooklyn, NY 11202-9814

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

通過抵降保費計劃，您可以向醫療補助支付超額金額(超出醫療補助收入限制的金額)，或者提交總計達到該金額的醫療保健費用賬單。無論以哪種方式抵降保費，您都可以在本月剩餘時間獲得完整的醫療補助保險。

資產: 包括現金、銀行賬戶、退休賬戶和股票。某些資產不計入這些限制，包括您的主要住宅、汽車和個人物品。社區醫療補助申請者必須在申請當月記錄資產 社區醫療補助的資產 轉移沒有回溯期，但申請以社區為基礎的長期護理服務的除外。對於以社區為基礎的醫療補助承保的長期護理服務，紐約州將實施 30 個月的回溯期，從 2020 年 10 月 1 日或之後進行的轉移開始，逐步實施。回溯的實施已推遲到至少 2022 年 7 月。回顧將適用於家庭護理服務的新申請；那些已經註冊的人不會對資產轉移進行任何回顧。尋求在生效日期之前提交的基於社區的長期護理保險的申請人將沒有回溯期。

有關醫療補助如何計算收入和資產的完整列表，請瀏覽醫療補助參考指南，網址為 www.health.ny.gov/health_care/medicaid/reference/mrg/。如果您的收入和/或資產超過醫療補助允許的金額，您可能需要考慮申請醫療保險儲蓄計劃，以幫助支付醫療保險保費和其他與醫療保險相關的費用(參見第 38 頁)。

醫療補助申請: 申請人填寫 Access NY Health Care 申請表 DOH 4220 以及補充 A。您可以在以下網址獲取申請表和說明

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

我在哪裡提交申請？

您可以選擇提交醫療補助申請的地點和方式：

聯絡您附近的便利註冊人尋求幫助。致電 347-396-4705 或查看 www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf 以獲取註冊者列表。前往您當地的醫療補助辦公室。您可以在辦公室親自填寫申請表獲得幫助，或將填寫好的申請表交給您。要查找您附近的 Medicaid 辦事處，請參見第 55 頁，致電 311 並詢問人力資源管理局，或瀏覽 www1.nyc.gov/site/hra/locations/medicaid-locations.page。

通過郵件提交申請。將填妥的申請表連同證明文件郵寄至：

Initial Eligibility Unit
HRA/Medical Assistance Program
PO Box 24390 Brooklyn, NY 11202-9814

您也可以將您的申請傳真至 917-639-0732。您的授權代表可以將申請傳真至 917-639-0731。

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

Eliminating the Spenddown for Medicaid Applicants

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

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

How does Medicaid work with Medicare?

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

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

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

How does Medicaid interact with Medicare Part D?

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

重新認證：醫療補助的授權期限為12個月。在保險的第9個月左右，HRA會郵寄一份重新認證的資料，必須填寫，以便確定持續的資格。

消除醫療補助申請人的支出

需要社區醫療補助服務(包括家庭護理、成人日托和處方藥保險)的任何年齡的殘疾人士都可以通過參與補充需求信託，利用他們的所有收入來支付生活費用。建立補充需求信託消除了個人將其「超額」或支出金額貢獻給**聯邦醫療補助的需要**。由非營利機構管理的集合收入信託基金接收個人每月的盈餘收入，並按照他們或其法定代表的指示，代表他們重新分配以支付租金、水電費等費用。

如需更多資訊，請致電 212-613-7310 聯絡紐約法律援助小組的 Evelyn Frank 法律資源計劃，或發送電郵至 EFLRP@NYLAG.org。

醫療補助如何與醫療保險合作？

可以同時擁有醫療保險和醫療補助。同時擁有醫療保險和醫療補助的人被稱為「雙重資格」。醫療保險是主要覆蓋範圍，醫療補助是次要覆蓋範圍。除了消除醫療保險的費用分攤要求，例如 A 部分免賠額和 B 部分免賠額以及 20% 的共同保險，(當他們使用同時接受醫療保險和醫療補助的提供者時)紐約的醫療補助還提供一些未涵蓋的福利醫療保險計劃，例如家庭保健以及牙科和視力服務。

與所有醫療保險受益人一樣，雙重資格可以選擇他們如何獲得醫療保險和醫療補助福利。與提供者確認他們接受承保範圍很重要。以下是雙重資格獲得醫療保險和醫療補助福利的不同方式：

- 原始醫療保險(紅、白、藍卡)+ 醫療補助服務費(紐約州福利卡)+ 醫療保險 D 部分計劃。
- 特殊需求計劃 (SNP) 專為雙重資格而設計 – SNP 是提供所有醫療保險 A、B 和 D 福利的 HMO。
- 帶有 D 部分的醫療保險優勢計劃 + 按服務收費的 醫療補助(紐約州福利卡)。

醫療補助如何與醫療保險 D 部分互動？

符合雙重條件的人會自動加入完整的額外幫助計劃(參見第 33 頁)，如果他們沒有自行註冊，則會自動加入 D 部分計劃。參加「基本」D 部分計劃的雙重資格將不為 D 部分保險支付保費。到 2022 年，收入低於聯邦貧困線 (FPL) 100% 的雙重資格將有 \$1.35 的仿製藥共付額/\$4.00 的品牌處方藥。收入超過 100% FPL 的人將有 \$3.95 的仿製藥共付額/ 2022 年名牌處方藥 \$9.85。

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

Medicaid Managed Long Term Care

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

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

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

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

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

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

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

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

For further information on the types of managed long-term care plans, visit:

MLTC, MAP+ and PACE:

https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_guide_e.pdf

Plan Directory: https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

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

根據法律，某些藥物不在 D 部分的涵蓋範圍內，例如非處方藥和維生素。這些可能由醫療補助通過處方承保。

醫療補助管理的長期護理

為個人護理服務、家庭護理服務或私人護理申請醫療補助
雙重資格需要醫療補助承保的個人護理、家庭護理或私人護理服務必須首先申請醫療補助並獲得醫療補助批准（有或沒有支出計劃），然後按照以下步驟操作：

請致電 855-222-8350 聯絡 New York Medicaid Choice/Maximus，以評估您對家庭護理服務的需求。

如果您獲准享受醫療補助承保的長期護理，您將需要加入醫療補助管理的長期護理計劃。您將在郵件中收到一個包裹，通知您的選擇以及如何註冊。如果您不為自己選擇計劃，您將自動加入管理式長期護理計劃（請參閱以下第一點）。

有三種類型的管理式長期護理計劃可供選擇：

管理式長期護理 (MLTC)：MLTC 計劃主要提供長期護理服務。這是管理式長期護理計劃選項中最靈活的一種，因為參保者繼續將其當前的醫療保險和醫療補助計劃用於長期護理服務以外的所有服務。

醫療補助額外優勢計劃 (MAPlus)：MAPlus 成員通過一個計劃獲得所有醫療補助和醫療保險服務，包括長期護理服務，並且必須使用網絡內提供者。

長者全包式護理計劃 (PACE)：PACE 計劃成員接受他們所有的醫療補助和醫療保險服務，包括長期護理服務。通過一個計劃，並且必須使用網絡內提供者。PACE 計劃與 MAPlus 計劃的不同之處在於，參保者必須年滿 55 歲才能加入 PACE，並且 PACE 計劃通過特定地點（例如醫療診所或醫院）提供服務。

有關管理式長期護理計劃類型的更多資訊，請瀏覽：

MLTC、MAP+ 及 PACE:

https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_guide_e.pdf

Plan Directory: https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

對於急需家庭護理服務的醫療補助申請人，有一個程序可以在 7 天內獲得醫療補助批准，並在 12 天內獲得家庭護理批准。這是 HRA 醫療補助警報的訊結，當中列明了該程序：
www.wnyc.com/health/afile/203/614/。

How will managed long term care work with a Medicaid Spenddown?

Many people have Medicaid with a spenddown to help them pay for Medicaid-covered home care services. These individuals pay their Medicaid spenddown to the health plan. If a member does not pay the spenddown, the plan can disenroll the member.

How do I select a plan?

Decide what type of plan would best suit your needs (MLTC, MAPlus, or PACE).

Ask your providers (home care agency, medical providers, etc.) what plans they participate in so that you can pick a plan that will allow you to continue seeing your providers. If you wish to enroll in a MAPlus or PACE plan, you also need to get your Part D drug coverage through that plan; the Plan Finder at www.medicare.gov has the prescription drug information for these plans.

To enroll in the plan, call NY Medicaid Choice at 1-888-401-6582.

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

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

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

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

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

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

管理式長期護理如何與醫療補助抵降保費計劃一起使用？

許多人擁有醫療補助抵降保費計劃，以幫助他們支付醫療補助承保的家庭護理服務。這些人將他們的醫療補助抵降的保費支付給健康計劃。如果會員不支付預付款，該計劃可以取消該會員的註冊。

如何選擇計劃？

決定哪種類型的計劃最適合您的需求 (MLTC、MAPlus 或 PACE)。

詢問您的提供者 (家庭護理機構、醫療提供者等) 他們參與了哪些計劃，以便您可以選擇一個可以讓您繼續看您的提供者的計劃。如果您希望加入 MAPlus 或 PACE 計劃，您還需要通過該計劃獲得 D 部分藥物承保；www.medicare.gov 上的計劃瀏覽器提供這些計劃的處方藥資訊。

要加入該計劃，請致電 1-888-401-6582 聯絡 NY Medicaid Choice。

我如何獲得管理式長期護理計劃的幫助？

獨立消費者權益倡導網絡 (ICAN) 是紐約州的監察員計劃，旨在幫助通過醫療補助管理式護理 (包括 MLTC、MAPlus、PACE 和主流醫療補助 (提供長期護理服務) 接受長期護理服務的人們。可以致電 1-844-614-8800 聯絡 ICAN。

機構醫療補助：收入和資產指南對機構醫療補助非常嚴格。一般來說，療養院的居民必須將大部分收入，除了每月的少量「個人護理」津貼用於支付療養院的費用，除非他們預計要回家。如果他們的配偶仍然住在家裡，規則會更加靈活。

護理機構應幫助準備和提交機構醫療補助申請。除了常規的社區醫療補助申請外，申請人還必須提供過去 5 年的資產文件。這 5 年的「回顧期」使醫療補助能夠識別為符合醫療補助資格而進行的無償轉移。

如果在 5 年回顧期內發現任何此類轉移，醫療補助將處以「轉移罰款」，這意味著它不會在與轉移金額成正比的一段時間內支付申請人的療養院住宿費用。

社區配偶保護：當一名配偶進入長期護理機構時，留在家中的配偶因支付護理費用而免受經濟貧困。聯邦和紐約州法律規定，社區配偶可以保留這對夫婦的房屋、汽車、個人物品以及他們共同資產中的一筆錢。

NY STATE OF HEALTH/HEALTH INSURANCE EXCHANGE

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

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

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

NY State of Health evaluates eligibility for the following types of health insurance:

MAGI Medicaid, for those under 65, not blind or disabled: Income up to 138% of FPL. Can apply year-round. No resource limit.

Essential Plan: Income from 138% to 200% of FPL for those under 65. Can apply year-round. No resource limit.

“Qualified Health Plan” (QHP), with or without a federal subsidy; Can apply only during the annual open enrollment period, unless applicant has a qualifying event. No resource limit.

How to apply for coverage through the Marketplace:

Apply online at www.nystateofhealth.ny.gov.

Receive free application assistance through a navigator. Visit <https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations> for a listing of navigators in New York.

Call the New York State of Health Customer Service Center at 1-855-355-5777.

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

紐約州健康/健康保險交易所

- 為 65 歲以下、非盲人或殘疾人士提供的醫療補助
 - 基本計劃
 - 合格的健康計劃

健康保險交易所是一個有組織的購買健康保險的市場。在紐約州，該交易所被稱為紐約州健康：官方健康計劃市場。紐約市的市場提供許多健康保險選項。市場計劃提供全面的健康保險，並具有成本分攤結構，其中包括保費、免賠額、共付額和最高自付費用。通過市場提供保險的所有計劃都是 HMO，這是最嚴格的管理式醫療形式。在紐約市，您必須選擇服務於您居住區的計劃。

根據《聯邦平價醫療法案》，您不能因已有疾病而被拒絕購買健康保險，有此類疾病的人不能為健康保險支付更多費用，也不能有等待期來接受針對已有疾病的護理。這些規則適用於通過市場或在市場之外購買的計劃。

健康紐約州評估以下類型健康保險的資格：

MAGI 醫療補助，適用於 65 歲以下、非盲人或殘疾人：收入高達 FPL 的 138%。全年均可申請。沒有資源限制。

基本計劃：65 歲以下人士的收入為 FPL 的 138% 至 200%，可以全年申請，沒有資源限制。

「合格的健康計劃」(QHP)，有或沒有聯邦補貼；只能在年度公開註冊期間申請，除非申請人有符合條件的活動。沒有資源限制。

如何通過市場申請保險：

在 www.nystateofhealth.ny.gov 網上申請。

通過導航器獲得免費的申請幫助。瀏覽<https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations> 以獲取紐約的導航員列表。

請致電 1-855-355-5777 聯絡紐約州衛生客戶服務中心。

健康紐約州將首先評估您的 **MAGI 醫療補助** 資格。如果不符合 **MAGI 醫療補助** 的資格，您將接受基本計劃的評估。如果不符合基本計劃的資格，您將接受合格健康計劃 (QHP) 的評估。有些人有資格獲得聯邦補貼來購買 QHP。那些沒有資格獲得補貼的人支付該計劃的全部費用。您必須是居住在紐約的公民或合法永久居民才能通過紐約市場購買計劃。

How does other insurance interact with Marketplace plans?

If you have non-MAGI Medicaid, you do not need to purchase other health insurance.

If you have Medicare, you do not need to purchase health insurance through the Marketplace. People with Medicare generally CANNOT enroll in a Marketplace plan. Medicare beneficiaries cannot get a federal subsidy to purchase a plan.

If you are receiving Social Security Disability Insurance (SSDI) and are in the 24-month waiting period for Medicare coverage to begin, you may want to look into a Marketplace plan. When you become Medicare eligible, you can drop your Marketplace plan. You will need to decide how to get your Medicare benefits – either Original Medicare or a Medicare Advantage plan.

MAGI MEDICAID FOR PEOPLE UNDER 65, NOT BLIND OR DISABLED

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

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

What happens to my MAGI Medicaid through the Marketplace when I become Medicare eligible due to turning 65 or disability?⁴

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

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

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

其他保險如何與市場計劃互動？

如果您擁有非 MAGI 醫療補助，則無需購買其他健康保險。

如果您有醫療保險，則無需通過市場購買健康保險。擁有醫療保險的人通常不能參加市場計劃。醫療保險受益人無法獲得聯邦補貼來購買計劃。

如果您正在接受社會保障殘疾保險 (SSDI) 並且處於醫療保險開始的 24 個月等待期，您可能需要查看市場計劃。當您符合醫療保險資格時，您可以放棄您的市場計劃。您將需要決定如何獲得您的醫療保險福利——原始醫療保險或醫療保險優勢計劃。

65 歲以下人士、非盲人或殘疾人士的 MAGI 醫療補助

孕婦、18 歲以下的兒童、父母/看護親屬和 19 至 64 歲的無子女成年人根據 MAGI (修改後的調整總收入) 預算進行醫療補助資格評估。那些收入高達 FPL 138% 的人，估計 2022 年個人每月 \$1,482 / 夫妻每月 \$2,004，可能有資格獲得 MAGI 醫療補助。19 歲以下的兒童有資格獲得更高收入水平的 MAGI 醫療補助。沒有資源限制。個人將通過管理式醫療計劃 (HMO) 獲得醫療補助福利，該計劃應在申請時選擇。MAGI 醫療補助重新認證每年進行一次。

被確定為殘疾的個人，包括那些接受社會保障殘疾保險但尚未接受醫療保險的人，以及 65 歲及以上的父母/看護親屬（即使接受醫療保險）的人士，可能有資格獲得這些醫療補助 MAGI 等級。

當我因年滿 65 歲或殘疾而符合醫療保險資格時，我通過市場獲得的 MAGI 醫療補助會發生什麼事？⁴

通過市場獲得 MAGI 醫療補助的個人在年滿 65 歲或因殘疾而獲得醫療保險時無法維持市場保險，儘管兩種情況的過渡過程不同。例外：未成年子女的父母/看守親屬可以通過紐約州衛生局維持 MAGI 醫療補助並擁有醫療保險。所有從市場醫療補助過渡到醫療保險的個人都將自動獲得 D 部分的額外幫助（參見第 33 頁）。

65 歲符合醫療保險資格：接近 65 歲的人將其醫療補助案件轉移到紐約市人力資源管理局 (HRA)。HRA 將郵寄表格供他們填寫並返回。這些表格使 HRA 能夠評估個人是否可以在較低的非 MAGI 水平上繼續享受醫療補助。如果個人希望接受持續的醫療補助資格評估，則應回復任何 HRA 郵件。在進行評估時，HRA 將給予他們大約四個月的醫療補助資格。在此期間，他們可以使用紐約州福利卡並從任何接受醫療補助的提供者處獲得按服務收費的醫療補助。

⁴ 注意：在突發公共衛生事件 (PHE) 期間，以下流程已暫停。在此期間成為醫療保險資格的個人將維持其 MAGI 醫療補助承保範圍

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

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

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

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

THE ESSENTIAL PLAN

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

Enrollment in the Essential Plan takes place year-round.

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

QUALIFIED HEALTH PLANS

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

When can I enroll in a Qualified Health Plan?

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

領取社會保障福利的人將在 65 歲時自動加入醫療保險。那些未在 65 歲時領取社會保障福利的人應在其 7 個月的初始註冊期間(參見第 6 頁)申請醫療保險, 因為申請醫療保險是如果超過 65 歲, 可以享受醫療補助。

如果個人選擇通過原始醫療保險獲得福利, 則未能獲得持續醫療補助資格的個人可能需要考慮加入醫療保險優勢計劃或購買補充保險保單。他們將在日曆年的剩餘時間內獲得全部額外幫助(參見第 33 頁), 並且健康紐約州將退還 B 部分保費, 同時他們繼續享有醫療補助承保。

獲得持續醫療補助批准的個人可以選擇如何獲得醫療保險和醫療補助福利。

因殘疾而符合醫療保險資格: 在收到 24 個月的社會保障殘疾保險 (SSDI) 付款後, 個人成為醫療保險資格並自動收到一張醫療保險卡。他們將在 12 個月的醫療補助授權期結束之前維持其市場醫療補助覆蓋範圍; 但他們將使用醫療保險和醫療補助卡而不是他們的醫療補助 HMO 計劃卡來獲得醫療服務。醫療保險是他們的主要健康保險公司, 而醫療補助是他們的次要保險。隨著他們 12 個月的授權期接近尾聲, 他們的醫療補助案件從健康紐約州轉移到 HRA。HRA 將向他們郵寄表格, 以評估他們是否符合持續的醫療補助資格。他們應加入最能涵蓋其藥物的 D 部分計劃; 如果他們不選擇計劃, 他們將自動加入計劃。

基本計劃

基本計劃適用於 65 歲以下、月收入介於 FPL 的 138% 和 - 200% 之間的人, 到 2022 年, 個人估計高達 \$2,265, 二口之家估計高達 \$3,052。基本計劃中的人可以選擇參加基本健康計劃, 每月將支付 \$0 或 \$20 的保費。

基本計劃的註冊全年進行。

成為醫療保險資格的基本計劃參保者不再有資格參加基本計劃。他們將收到來自健康紐約州的通知, 說明他們的註冊即將結束。這些人應在 7 個月的初始註冊期間(參見第 6 頁)投保醫療保險 A、B 和 D, 並且可能需要考慮補充保險。

合格的健康計劃

任何人都可以購買合格的健康計劃; 年收入低於聯邦貧困線 400% 的人(2021 年個人估計為 \$51,520, 四口之家估計為 \$106,000), 可能有資格以稅收抵免的形式獲得聯邦補貼, 以幫助支付費用的一個計劃。

我什麼時候可以加入合格的健康計劃?

市場的公開註冊每年進行一次, 通常是從 11 月 1 日到 1 月 31 日。1 月 31 日之後, 您需要等待下一個年度公開註冊期才能註冊。

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

There are several ways to learn more about Marketplace plans:

Reach out to a “Navigator.” Navigators are organizations in your community that can help you select and enroll in a plan. To find a navigator near you, go to <https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations> or call the Community Health Advocates at 1-888-614-5400.

Contact New York State of Health, operated by Maximus, at 1-855-355-5777, Monday-Friday, 8 am–5 pm.

Visit nystateofhealth.ny.gov.

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

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

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

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

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

有一些例外情況允許您在年中註冊，包括失去當前的健康保險。

有多種方法可以了解有關市場計劃的更多資訊：

聯絡「導航員」。導航員是您社區中可以幫助您選擇和註冊計劃的組織。要查找您附近的導航員，請瀏覽 <https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations> 或致電 1-888-614-5400 聯絡社區健康倡導者。

週一至週五上午 8 點至下午 5 點，請致電 1-855-355-5777 聯絡由 Maximus 營運的紐約州衛生局。瀏覽 nystateofhealth.ny.gov。

通常建議擁有 **QHP** (市場計劃) 且符合醫療保險資格的人在首次符合資格時加入醫療保險，並通過通知他們的計劃放棄 QHP 這是因為：

- 成為醫療保險資格後，不能繼續獲得任何保費補貼或費用分攤減免 (以幫助支付 QHP 保費)。
- 擁有 QHP 並不會延長他們參加醫療保險的時間。延遲註冊可能意味著覆蓋範圍的差距和延遲註冊的罰款。

受益人有責任在初始註冊期間投保醫療保險 A、B 和 D (有關更多資訊，請參閱第 6 頁)，並放棄 QHP 承保。

可能想要仔細考慮 **QHP** 與醫療保險的人是：

- 不符合免費 A 部分的資格。他們可能會獲得 QHP 保險的保費補貼或費用分攤減少，但前提是他們不參加 A 或 B 部分。如果他們希望以後參加醫療保險，他們對於醫療保險 A 和 B，將會有延遲和延遲註冊處罰。
- 未滿 65 歲且患有終末期腎病。

VETERANS' BENEFITS AND TRICARE FOR LIFE

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

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

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

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

The VA cannot bill Medicare, so veterans with Medicare only who are responsible for the co-pay for medical care will be billed the appropriate charge for services. However, if they have a supplemental policy, the VA will bill the supplemental insurer first.

In some circumstances, the VA may pre-authorize services in a non-VA hospital or other care setting. Veterans may need to pay a VA copayment for non-service-connected care. If not, all services are authorized to be covered by the VA, then Medicare may pay for other services the veteran patients may need during their stay.

How do VA benefits interact with Medicare Part A and Part B?

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

How does VA drug coverage interact with Medicare Part D?

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

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

退伍軍人福利和終身保障

要在退伍軍人事務部 (VA) 營運的設施接受醫療保健, 退伍軍人必須在 VA 註冊。退伍軍人可以隨時申請保險。

入伍退伍軍人不需要提交他們的收入資訊。但是, 某些退伍軍人將被要求完成財務評估, 以確定他們是否有資格獲得免費醫療、藥物和/或旅行福利。

自 2015 年起, 弗吉尼亞州不再使用淨資產作為醫療保健計劃和共付額責任的決定因素。VA 現在只考慮退伍軍人的家庭總收入和上一年的可扣除費用。某些收入較低、與服務無關的退伍軍人將有更少的自付費用。要了解更多資訊, 請瀏覽 www.va.gov/healthbenefits/apps/explorer/AnnualIncomeLimits/HealthBenefits。

不符合免費護理條件的退伍軍人需承擔共同支付費用。

VA 不能向醫療保險開賬單, 因此只有負責共同支付醫療費用的醫療保險退伍軍人才會被收取相應的服務費用。但是, 如果他們有補充保單, 則 VA 將首先向補充保險公司開具賬單。在某些情況下, VA 可能會預先授權非 VA 醫院或其他護理環境中的服務。退伍軍人可能需要為與服務無關的護理支付 VA 共付額。如果不是, 則所有服務都被授權由 VA 承保, 那麼醫療保險可能會支付老患者在住院期間可能需要的其他服務。

VA 福利如何與醫療保險 A 部分和 B 部分互動?

醫療保險 A 部分和 B 部分獨立於 VA 衛生系統工作。出於這個原因, 那些有資格獲得醫療保險的人可能希望註冊使用 VA 醫療保健系統之外的醫院和提供者。如果他們在第一次符合條件時沒有加入醫療保險, 並且不符合特殊註冊期的條件, 他們可能需要承擔 B 部分延遲投保罰款。

VA 藥物承保範圍如何與醫療保險 D 部分互動?

VA 的處方藥保險被認為是信賴的, 這代表它與醫療保險 D 部分一樣好或更好。可以同時擁有 D 部分計劃和 VA 藥物承保。那些選擇放棄 D 部分但後來希望參加 D 部分的人, 將不會因延遲註冊而受到處罰。但是, 他們需要等到年度公開註冊期(10 月 15 日至 12 月 7 日)才能註冊, 從 1 月 1 日開始承保, 除非他們有資格參加特殊註冊期。

軍人醫療保險健康福利為現役軍人及其家人、在現役期間死亡的軍人家屬、前配偶、退休人員及其家人(無論退休人員是否殘疾)以及國民警衛隊/預備役成員提供保險。服役至少 20 年、年滿 65 歲且目前參加聯邦醫療保險 A 部分和 B 部分的軍人退休人員(及其配偶)有資格獲得終身軍人醫療保險(TFL)。TFL 是一項免保費醫療保健計劃, 可作為醫療保險的補充, 包括可靠的藥物保險。

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

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

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

OTHER HEALTH COVERAGE OPTIONS FOR NEW YORKERS

COBRA

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

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

HHC Options

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

Federally Qualified Health Centers

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

有關終身軍人醫療保險的更多資訊, 請致電 1-866-773-0404 或瀏覽 www.tricare.mil。

平民健康和醫療計劃 (CHAMPVA) 是一項健康保險計劃, 適用於患有永久性和完全服務相關殘疾的退伍軍人家屬。大多數醫療保險和軍人醫療保險提供者也將接受 CHAMPVA (但一定要詢問提供者)。符合軍人醫療保險條件的人不能參加 CHAMPVA。有關 CHAMPVA 的更多資訊, 請致電 1-800-733-8387 聯絡 VA 或瀏覽 www.va.gov

有關健康 VA 福利的更多資訊, 請致電 1-877-222-8387 (中部時間上午 7 點至晚上 7 點開放) 或瀏覽 www.va.gov。

紐約人的其他健康保險選擇

COBRA

聯邦法律要求擁有 20 名或更多員工的僱主為離職員工提供 COBRA 作為基於僱主的醫療保險的「延續」。在紐約州, 大多數人可以獲得長達 36 個月的 COBRA 保險。COBRA 可以彌補差距, 直到您繼續享受醫療保險或接受提供健康保險的新工作。如果您因死亡或離婚而退休、離職、被解僱、工作時間縮短或通過積極工作的配偶失去您的保險, 您就有資格獲得保險。您的配偶和家屬也有權從您的 COBRA 保險中受益。

如果您在符合 Medicare 資格之前已使用 COBRA, 則 COBRA 通常會在醫療保險開始時停止。如果您已經有資格獲得醫療保險並且仍在工作, 您可以在停止工作後選擇 COBRA。如果您同時擁有醫療保險和 COBRA, 則醫療保險是主要的, COBRA 是次要的。即使 COBRA 的費用由前僱主提供補貼, COBRA 保險也不允許有人延遲加入 B 部分而不受處罰。

HHC 選擇計劃

HHC 選擇計劃是紐約市健康+醫院 (HHC) 的一項計劃, 使中低收入的個人和家庭能夠通過 HHC 的醫院和衛生設施網絡以滑動收費的方式獲得醫療保健。參加 HHC 選項不收取任何費用; 您在獲得護理時付費。HHC 在確定資格時不看移民身份。如需更多資訊, 請瀏覽 <https://www.nychealthandhospitals.org/paying-for-your-health-care/financial-assistance/> 或致電 1-844-692-4692。

符合聯邦標準的健康醫療中心

符合聯邦標準的健康醫療中心 (FQHC) 是綜合性健康中心, 可為所有年齡段的人提供初級保健、心理健康和藥物濫用治療、牙科保健和處方藥。儘管 FQHC 接受健康保險, 但他們也看到沒有保險的患者採用滑動收費標準, 根據患者的收入向他們收費。對於符合條件的醫療保險受益人, FQHC 可以免除年度 B 部分免賠額和 20% 的共同保險。要查找 FQHC 位置, 請瀏覽 <https://findahealthcenter.hrsa.gov/>。

致電 212-AGING-NYC (212-244-6469) 並詢問 HIICAP

Health Insurance & Self Employment

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

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

MEDICARE 2022

Part A: Hospital Insurance

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

Part B: Medical Insurance

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

Some people 65 or older do not meet the SSA requirements for **premium-free Hospital**
Call 212-AGING-NYC (212-244-6469) and ask for HIICAP

健康保險和自僱

有些職業提供團體保險。請諮詢您的前僱主和/或您所屬的任何專業協會會員。以下是一些可能有用的資源。

Small Business Service Bureau	小企業員工	800-472-7199 www.sbsb.com
Graphic Artists Guild	平面藝術家	1-212-791-3400 graphicartistsguild.org
National Writers Union	作家	315-545-5034 www.nwu.org
Screen Actors Guild	表演者	1-212-944-1030 www.sagaftra.org
Freelancer's Union	獨立工作者	www.freelancersunion.org

醫療保險 2022 年

A 部分：醫院保險

免賠額	每個福利期 \$1,556
共付額	每個福利期的第 61-90 天每天 \$389
	每個「終身保留日」每天 \$778
專業護理機構共付額	每個福利期的第 21-100 天每天 \$194.50

B 部分：醫療保險

每月保費	大多數醫療保險受益人支付 \$170.10 的標準保費，以下情況除外： ● 那些社會保障生活成本調整 (COLA) 沒有增加到足以將 B 部分保費提高到 \$170.10 水平的人。 ● 更高收入 (超過 \$91,000 的單身/\$182,000 夫婦) 受益人，他們支付的金額更高。
每年免賠額	\$233
共同保險	大多數服務 20%

一些 65 歲或以上的人不符合免費醫院的 SSA 要求
致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

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

Medicare Savings Program 2022

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

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

MEDICAID 2022

Standard Medicaid		
Maximum Income and Asset Levels* for those who are blind, disabled or age 65 and over:		
*The first \$20 of income is exempt. Above figures are prior to the \$20 disregard. You are permitted a burial fund allowance of \$1,500 per person.		
	Monthly Income	Assets
Individual	\$934	\$16,800
Couple	\$1,367	\$24,600

Nursing Home-Based Medicaid

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

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

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

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

保險(A 部分)。如果您屬於此類別, 您可以通過支付每月保費獲得 A 部分。在 2022 年, 如果您的社會保障保險少於 30 個季度, 您的每月 A 部分保費為 \$499。如果您有 30 至 39 個季度的社會保障保險, 您每月的 A 部分保費為 \$274。

2022 年醫療保險儲蓄計劃

	月收入	
	個人	夫婦
QMB - 合格的醫療保險受益人 紐約州為自動符合 A 部分資格的人支付保費、免賠額和共同保險。	\$1,153	\$1,546
SLMB - 指定的低收入醫療保險受益人水平 州僅支付醫療保險B 部分保費。	\$1,379	\$1,851
QI - 合格人士 州僅支付醫療保險 B 部分保費。	\$1,549	\$2,080

注意: 上面列出的金額包括標準的 \$20 收入不計。

醫療補助 2022 年

標準醫療補助

盲人、殘疾人或 65 歲及以上人士的最高收入和資產水平*:

*收入的前 \$20 是豁免的。以上數字是在\$20 的豁免之前。您被允許獲得每人\$1500 的殮葬費補貼。

	月收入	資產
個人	\$934	\$16,800
夫婦	\$1,367	\$24,600

以療養院為基礎的醫療補助

收入 - 當療養院居民有資格獲得醫療補助支持時, 所有收入都將用於療養院, 但每月 \$50 的居民個人需求津貼除外。

資產 - 所有個人資產必須首先用完以支付費用 (不包括主要住宅、汽車和個人財產)。

夫婦 - 當一個配偶有資格在療養院獲得醫療補助支持時, 社區配偶 (留在家中的一方) 有權保留屬於這對夫婦的一些收入和資源, 而醫療補助則支付住宅配偶護理費用。

社區配偶可以保留以下	
資源	最低 \$74,820; 最高 \$137,400
收入:	每月 \$3,435
有關醫療補助的更多資訊, 請致電 HRA 的醫療補助幫助熱線 1-888-692-6116	

致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

Medicaid Offices in New York City

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

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

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

紐約市的醫療補助辦公室

醫療補助申請人可以致電醫療補助幫助熱線 1-888-692-6116 查找最近的醫療補助辦公室、辦公時間和方向。紐約市居民可以在五個行政區的任何辦公室申請。

注意：儘管大多數醫療補助辦公室在新冠肺炎公共衛生緊急事件後重新開放，但鼓勵人們僅在無法通過電話獲得幫助時才前往辦公室。

布朗克斯	福特漢姆: 2541-2549 Bainbridge Ave. (929) 252-3230 騎士: 305 Rider Avenue, 4th Floor. (718) 585-7872
布魯克林	康尼島: 3050 West 21st Street, 3rd Floor. (929) 221-3790 東紐約: 404 Pine Street, 2nd floor. 929-221-8204 金斯縣醫院: 441 Clarkson Avenue, "T" Building, Nurses Residence, 1st Floor. (718) 221-2300 ext. 2301 (closed until further notice) 布魯克林南部(中央醫療補助辦公室): 785 Atlantic Avenue, 1st Floor. (929) 221-3502
曼哈頓	唐人街: 115 Chrystie Street, 5 floor. (212) 334-6114 Dyckman Community: 4055 10th Avenue Lower Level (212) 939-0207 ext. 0208
皇后區	皇后區社區: 32-20 Northern Blvd., 3rd Floor. (718) 784-6729 牙買加: 165-08 88th Avenue, 8th Floor. 929-252-3193
斯塔滕島	斯塔滕島: 215 Bay Street. (929) 221-8823/8824

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

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

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

2022 年高收入醫療保險受益人的醫療保險 B 部分和 D 部分與收入相關的每月調整金額 (IRMAA)

2020 年修改後的調整後總收入 (MAGI)	B 部分每月保費	D 部分(處方藥)每月保費
MAGI 為 \$91,000 或以下的個人/ MAGI 為 \$182,000 或以下的夫婦	2022 標準保費 = \$170.10	您的計劃保費
MAGI 為 \$91,000-\$114,000 的個人/ MAGI 為 \$182,000-\$228,000 的夫婦	\$238.10	您的計劃保費 + \$12.40
MAGI 為 \$114,000-\$142,000 的個人/ MAGI 為 \$228,000-\$284,000 的夫婦	\$340.20	您的計劃保費 + \$32.10
MAGI 為 \$142,000-\$170,000 的個人/ MAGI 為 \$284,000-\$340,000 的夫婦	\$442.30	您的計劃保費 + \$51.70
MAGI 為 \$170,000-\$500,000 的個人/ MAGI 為 \$340,000-\$750,000 的夫婦	\$544.30	您的計劃保費 +\$71.30
MAGI 多於 \$500,000 的個人/ MAGI 多於 \$750,000 的夫婦	\$578.30	您的計劃保費 +\$77.90
MAGI 低於 \$91,000 的夫婦分開申請	\$170.10	您的計劃保費
MAGI 為 \$91,000 - \$409,00 的夫婦分開申請	\$544.30	您的計劃保費 +\$71.30
MAGI 多於 \$409,00 的夫婦分開申請	\$578.30	您的計劃保費 \$77.90

- 修改後的調整後總收入等於調整後總收入 + 免稅利息收入
- B 部分和 D 部分的 B 部分保費和 IRMAA 將從您的社會保障福利中扣除(如果您不領取社會保障福利, 則將收取費用)。
- 即使您直接向計劃支付 D 部分保費, D 部分附加費也會從您的社會保障支票中扣除(或在您未領取社會保障福利時計費)。

致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

Health Insurance Definitions

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

健康保險定義

名牌藥	具有商品名並受專利保護的藥物。只有擁有專利的公司才能生產和銷售。
共同保險	您必須為醫療保健支付的金額。它是護理總費用的百分比。
共付額	您為醫療服務支付的固定金額。
可靠的覆蓋範圍	與基本的醫療保險D部分藥物計劃一樣好或更好的處方藥承保範圍。
免賠額	在保險單開始支付之前，您必須每年支付的金額。
雙重資格	擁有醫療保險和醫療補助的人士。
聯邦貧困線 (FPL)	聯邦政府每年發布的收入衡量標準。這些金額用於確定某些計劃和福利的資格。
處方	處方藥計劃涵蓋的藥物清單。
仿製藥	與品牌藥具有相同活性成分配方的藥物。仿製藥的成本通常低於品牌藥。
與收入相關的每月調整金額 (IRMAA)	收入較高的人需要支付更高的醫療保險 B 部分和 D 部分保費。
原有疾病	在您的保險生效日期之前存在的健康問題。
保費	您為購買保險單而支付的金額。無論您是否使用任何健康服務，您都需要支付保費。
事先授權	為了讓保險公司承保藥物或服務，必須事先獲得批准。
數量限制	出於安全和/或成本原因，D 部分藥物計劃將在特定時間段內承保的處方藥數量限制。
逐步療法	D 部分藥物計劃施加的限制，要求您首先針對某種疾病嘗試一種藥物，然後才能承保針對該疾病的另一種藥物。

Resources for Assistance in Paying for Prescription Medications

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

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

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

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

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

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

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

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

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

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

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

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

協助支付處方藥的資源

(每個計劃都有自己的資格要求, 致電或查看網站以獲取更多資格資訊以及如何申請。)

ADAP(愛滋病藥物援助計劃)- 為治療 HIV/AIDS 和機會性感染提供免費藥物。ADAP 可以幫助有部分保險的人, 包括醫療保險 D 部分, 以及有醫療補助支出要求的人。致電 (800) 542-2437 或瀏覽 www.health.ny.gov/diseases/aids/general/resources/adap/eligibility.htm 了解更多資訊。

福利檢查 幫助人們找到他們可以獲得的福利和服務。 www.benefitscheckup.org

BigAppleRx 處方藥折扣卡紐約市贊助的免費折扣卡。無論年齡、收入、公民身份和健康保險狀況如何, 任何人都可以獲得該卡。折扣適用於品牌藥和仿製藥。瀏覽 www.BigAppleRx.com 或致電 1-888-454-5602 了解更多。

CancerCare Co-Payment Assistance Foundation 幫助癌症患者為其規定的治療支付共付額。瀏覽 www.cancercarecopay.org, 或致電 1-866-552-6729。

Good Days 幫助患有某些慢性病的人支付保險共付額。如需更多資訊以及符合條件的疾病和藥物清單, 請瀏覽 www.mygooddays.org, 或致電 1-877-968-7233。

GoodRx 讓您可以比較不同藥店的藥品成本。您可以搜索折扣和打印優惠券。瀏覽 GoodRx.com 了解更多。

HealthWell 基金會為符合條件的個人提供經濟援助, 以支付某些疾病患者的共同保險、共付額、醫療保健保費和免賠額。瀏覽 Healthwellfoundation.org 或致電 1-800-675-8416。

白血病和淋巴瘤協會共付額援助計劃幫助支付私人保險和醫療保險計劃的保費和共付額。瀏覽 <https://www.lls.org/support/information-specialists>, 或致電 1-800-955-4572。

醫學援助工具搜索引擎, 用於生物製藥行業提供的許多患者援助資源。瀏覽 www.medicineassistancetool.org。

國家骨髓患者援助計劃和經濟援助基金 - 如果保險不涵蓋全部費用, 可以幫助符合條件的個人支付骨髓或臍帶血移植的費用。瀏覽 www.bethematch.org 或致電 1-888-999-6743。

國家罕見疾病組織 (NORD) - 幫助有某些健康狀況的未投保或投保不足的個人獲得所需的藥物。瀏覽 www.rarediseases.org 或致電 1-800-999-6673。

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

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

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

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

Other Internet Resources

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

Health and Human Services Administration www.hhs.gov

HealthFinder.gov Information specific to particular health conditions

National Council on Aging www.ncoa.org

National Health Information Center www.health.gov/nhic

NeedyMeds.org 提供有關患者援助計劃 (PAP) 的資訊。瀏覽 www.needymeds.org 或致電 1-800-503-6897。

Patient Advocate Foundation Co-Pay Relief 幫助有某些診斷的符合條件的個人支付處方藥的共付額。瀏覽 www.copays.org, 或致電或 1-866-512-3861。

Patient Services Incorporated (現為 **Accessia Health**) 可能能夠幫助患有某些罕見或慢性病的人支付健康保險費和共付額/共同保險, 以及與旅行相關的費用。瀏覽 www.patientservicesinc.org 或致電 1-800-366-7741。

RX Hope 使人們能夠直接通過網站申請折扣和免費藥物。瀏覽 www.rxhope.com。

其他網上資源

勞工部關於COBRA、黑肺病等的資訊 www.DOL.gov

健康與人類服務管理局 www.hhs.gov

HealthFinder.gov 針對特定健康狀況的資訊

全國老齡化委員會 www.ncoa.org

國家健康資訊中心 www.health.gov/nhic

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

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

資源	電話
HIICAP Helpline – NYC Department for the Aging Aging Connect 並申請 SHIP/Hi CAPA www1.nyc.gov/site/dfta/services/health-insurance-assistance.page	1-212-AGING-NYC (212-244-6469)
Aging Connect – 紐約市長者部提供的服務 www.nyc.gov/aging	1-212-AGING-NYC (212-244-6469)
Access-A-Ride - http://web.mta.info/nyct/paratran/guide.htm	1-877-337-2017
宣傳、諮詢和權利服務項目 (ACES)	1-212-614-5552
紐約殘疾人獨立中心 www.cidny.org	1-212-674-2300 或 1-646-442-1520
醫療保險和醫療補助服務中心 (CMS) www.cms.gov	1-800-MEDICARE
哥倫比亞大學牙科醫學院教學診所 www.dental.columbia.edu/teaching-clinics	1-212-305-6100
社區健康倡導者 www.communityhealthadvocates.org	1-888-614-5400
長者護理定位器 www.eldercare.acl.gov	1-800-677-1116
長者醫藥保險 (EPIC) www.health.state.ny.us/health_care/epic/index.htm	1-800-332-3742
賦權健康資訊工具(免費和低成本的健康和社會服務資源目錄) - www.HiteSite.org	1-866-370-4483
健康和醫院公司) https://www.nychealthandhospitals.org/paying-for-your-health-care/financial-assistance/	1-844-NYC-4NYC
HRA 資訊熱線 – 適用於所有 HRA 計劃, 包括食品券、公共援助和醫療補助	1-718-557-1399
HRA 醫療補助熱線	1-888-692-6116
美國臨終關懷基金會 - www.hospicefoundation.org	1-800-854-3402
ICAN - 獨立消費者倡導網絡 - 醫療補助管理的長期護理監察員 - https://icannys.org/	1-844-614-8800
紐約法律服務- www.legalservicesnyc.org	1-844-614-8800
有限收入新合格過渡 (LINET) 計劃(由 Humana 管理)	1-800-783-1307

致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

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

資源	電話
Livanta - 質素改進組織(針對出院上訴和護理質量投訴)	1-866-815-5440
醫療補助為長者、盲人和殘疾人提供便利(也可以幫助申請醫療保險儲蓄計劃)	1-347-396-4705
醫療補助欺詐控制部門(紐約州總檢察長)	1-800-771-7755
醫療保險欺詐熱線(DHHS 監察長辦公室)	1-800-447-8477
醫療保險熱線	1-800-MEDICARE
醫療保險權利中心 www.medicarerights.org/ www.medicareinteractive.org	1-800-333-4114
New York Connects (有關長期護理服務和支持的資訊)	1-800-342-9871
紐約州衛生局專業醫療行為辦公室(醫生質素控制投訴)	1-800-663-6114
紐約法律援助集團 (NYLAG) 的 Evelyn Frank 法律資源計劃 - EFLRP@NYLAG.org	1-212-613-7310
紐約州衛生局(市場) - https://nystateofhealth.ny.gov	1-855-355-5777
紐約市衛生局 - www.nyc.gov/health	311
紐約州長期護理監察員計劃 https://ltcombudsman.ny.gov/	1-855-582-6769
紐約州衛生部 - 管理式護理計劃投訴	1-800-206-8125
紐約州金融服務部 - www.dfs.ny.gov	1-800-342-3736
紐約州醫療補助熱線	1-800-541-2831
紐約州長者公民辦公室幫助熱線 - www.aging.ny.gov	1-800-342-9871
紐約州受害者服務辦公室 - https://ovs.ny.gov/help-crime-victims	1-800-247-8035
紐約大學牙科診所 - www.nyu.edu/dental	1-212-998-9800
鐵路退休委員會 - www.rrb.gov	1-877-772-5772
SMP(高級醫療保險巡邏隊)報告紐約州醫療保險欺詐/濫用	1-800-333-4374
社會保障局 - www.socialsecurity.gov	1-800-772-1213 TTY 1-800-325-0778
美國退伍軍人事務部 - www.va.gov	1-800-827-1000

致電 212-AGING-NYC (212-244-6469) 並詢問HIICAP

NOTES

筆記

筆記

Eric Adams

Mayor

City of New York



Lorraine Cortés- Vázquez

Commissioner

NYC Department for the Aging

Eric Adams

市長

紐約市



Lorraine Cortés- Vázquez

專員

紐約市長者部