

# HIICAP Resource Guide

Revised 2021

## Chemung County Department of Aging and Long Term Care, NY Connects



### HIICAP

Health Insurance Information,  
Counseling and Assistance  
Program

Medicare questions? Call 607-737-5520.

[www.chemungcountyny.gov](http://www.chemungcountyny.gov)

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*Helping People Age Together with Independence, Opportunity and Dignity*



**HIICAP**  
Health Insurance Information,  
Counseling and Assistance  
Program

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

HIICAP is New York's source for free, confidential and impartial information about health care coverage. Please call the Chemung County Department of Aging and Long Term Care, NY Connects at 607-737-5520 and ask to speak with one of our trained counselors.

We have HIICAP counselors available to speak with you over the phone, email or other media or we can meet with you in person.

Please note that inclusion of specific health care benefit programs does not constitute endorsement of these programs on the part of the Chemung County Department of Aging.

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# MEDICARE

Medicare is the Federal health insurance program for people 65 years or older, younger disabled people and people with kidney failure (End Stage Renal Disease, ESRD).

Original Medicare includes:

- **Part A** - Hospital Insurance
- **Part B** - Medical Insurance

## Who is Eligible for Medicare?

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

## How eligibility differs for Part A vs. Part B:

- To qualify for premium-free Part A at 65, you or your spouse (including same-sex spouse) must be insured through Social Security (by having earned 40 quarters of coverage, this is directly tied to work history). 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 be either a U.S. Citizen or a legal permanent resident for five (5) consecutive years and age 65 or older.

## How Do I Enroll in Medicare?

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

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

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

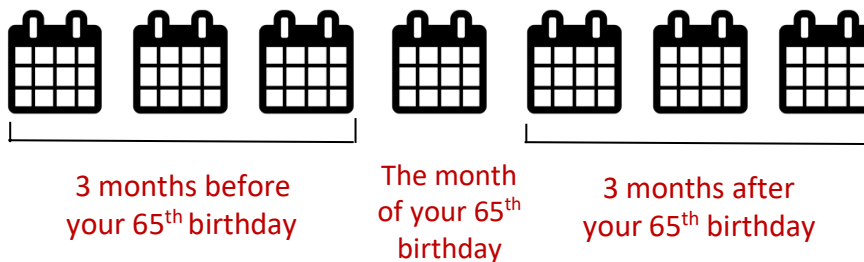
## Initial Enrollment Period (IEP)

If you are not collecting Social Security benefits when you turn 65, and you wish to enroll in Medicare Part B, you have a seven-month Initial Enrollment Period (IEP) in which to enroll in Medicare. The IEP is three months before you turn 65, the month in which you turn 65, and the three months that follow. The month you enroll 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 either **two or three months after your birthday**, your coverage will be effective three months later, from the month you enroll.

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

### When Is My 7-Month Initial Enrollment Period?



## Special Enrollment Period (SEP)

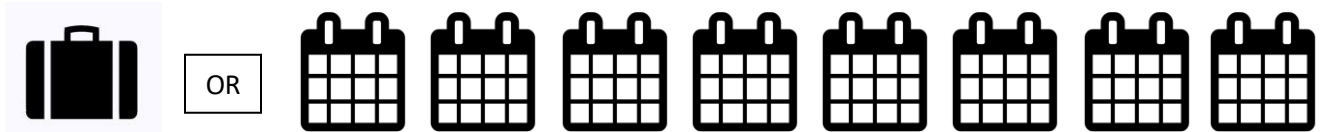
If you or your spouse are **actively employed** AND you have **health insurance** through that current/active employer or union, you may not need to enroll in Medicare Part B when you first become eligible; contact the employer or union to ask whether they require enrollment in Part B.

Having active employer-based coverage allows you to qualify for a SEP to enroll in Part B while still working, or within 8 months following the month in which you lose active employer-based health coverage. You will need your employer to complete a form, CMS-L564, Request for Employment Information, 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>. Social Security will need this form when you apply for your part B, this will advise them of your work history and coverage and let them know you shouldn't have a penalty.

**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 without incurring tax penalties, talk with your accountant.
- ✓ **COBRA or Retiree** coverage is NOT health insurance from an active employer and therefore does not allow one to qualify for a Special Enrollment Period.

### When Is My Special Enrollment Period?



While you have coverage  
from your employer

8-months after your employer-based coverage ends

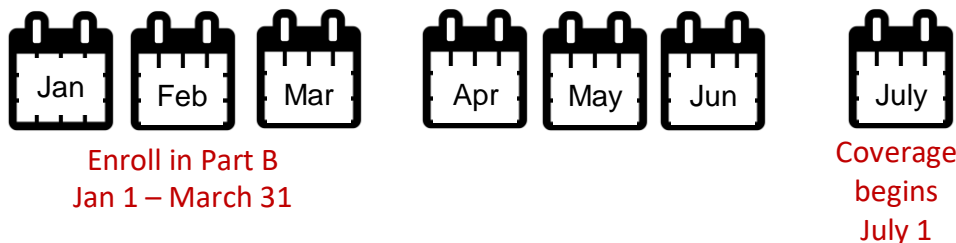
### General Enrollment Period (GEP)

If you do not enroll during your IEP and do not qualify for an SEP due to active employer-based coverage, you will have to wait until the General Enrollment Period (GEP) to enroll in Part B.

- The GEP is from January 1 to March 31 of each year. Your Part B coverage will not start until July 1<sup>st</sup> if you enroll during the GEP and you may be subject to a late enrollment penalty.
- The penalty for late enrollment is a 10% premium penalty **for every full 12 months** that you did not have either Medicare Part B or coverage from a current employer.
- This means that if you delayed Part B enrollment for 12 months, you would be paying the Part B premium + a 10% premium penalty based on the standard Part B premium for the current year. (If you delayed enrollment for 24 months, you will pay the part B premium + a 20% premium penalty, delay for 36 months, 30% penalty. You will pay the penalty for the life of your policy.)

You can apply for Medicare benefits by contacting the Social Security Administration, call 1-800-772-1213, visit a local Social Security office, or you may be able to enroll online at <https://www.ssa.gov/>

### When Is The General Enrollment Period?



**Enrolling in Medicare Part A** is more flexible than enrollment in Part B. Individuals eligible for **premium- free** Part A at age 65 can enroll in Medicare Part A at any time, and coverage can be retroactive up to six months, though not before the date they become Medicare-eligible.

\*Those who do not have **40 quarters** of work history through Social Security will not be eligible for **premium free** Part A but can apply for Part A and pay a premium. These individuals can only enroll during the Initial Enrollment Period, and thereafter only during the General Enrollment Period from January 1-March 31, with coverage effective July 1. These individuals may incur a Late Enrollment Penalty for their Part A.

**Medicare Card Replacement:** Medicare cards no longer have your Social Security number as an identifier. Your Medicare card has a randomly assigned identifier, known as a Medicare beneficiary identifier (MBI). The MBI is made up of 11 characters, consisting of both uppercase letters and numbers. If you need to replace your Medicare card, call 1-800-MEDICARE or create and log into your Medicare account <https://www.mymedicare.gov/> to print one.

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 or apply online for Medicare at <https://www.ssa.gov/>

# Medicare Part A Benefits

## Hospital

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

### **Inpatient Hospital Care:**

Medicare pays for medically necessary care in either a Medicare-certified general or psychiatric hospital. Medicare measures your coverage by benefit periods. 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 will pay for a lifetime maximum of 190 days of inpatient psychiatric care provided in a psychiatric hospital. After 190 days have been used, Medicare will pay for additional inpatient psychiatric care only in a general hospital.

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

### **Skilled Nursing Facility Care (inpatient rehabilitation):**

Care in a skilled nursing facility (SNF) is covered by Medicare Part A following a minimum three-day stay as an **inpatient in a hospital** (not counting the day of discharge). Medicare will help pay for up to 100 days in a SNF in a benefit period.

### **Observation Status**

Hospitals are required to provide Medicare beneficiaries with a Medicare Outpatient Observation Notice (MOON) if covered by Original Medicare and they are being held under "observation" for more than 24 hours. Observation is covered by [Part B](#), not [Part A](#), and does not count towards the minimum 3-day inpatient stay that allows for Medicare Part A coverage in a Skilled Nursing Facility. It's important to know if you are in the hospital as an inpatient or outpatient (under Observation).

**Home Health Care:** If you are homebound and require skilled care for an injury or illness, Medicare can pay for care provided in your home by a Medicare participating home health agency. Home care can be covered by either Part A or Part B, and is covered at 100%. [Part A](#) covers up to 100 days of home care following a **minimum 3-day inpatient stay**, or a **covered stay in a SNF**. [Part B](#) covers home care under other circumstances; a prior stay in the hospital is not required to qualify for home health care covered under Part B. The services may be provided on a part-time or intermittent basis, not full-time. Coverage is provided for skilled care, including skilled nursing care, physical, occupational, and speech therapy. If you are receiving skilled home care, you may also qualify for other home care services, such as a home health aide and medical social worker.



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

### **Part A Costs (2021)**

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

- Those without 40 quarters of coverage with Social Security can pay a monthly premium for Part A coverage.
  - If you have less than 30 quarters of Social Security coverage, your Part A premium will be \$471 a month. If you have at least 30 quarters of Social Security coverage, your Part A premium will be \$259 per month.
  - The QMB Medicare Savings Program may be able to pay the Part A premium for those who do not qualify for premium-free Part A. QMB is an income-based program.

#### **Inpatient Hospital Costs:**

**Deductible:** \$1,484 per benefit period (covers days 1-60) \*you may have more than one deductible to pay in a year depending on benefit periods.

#### **Additional cost sharing:**

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

#### **Skilled Nursing Facility Costs:**

Days 1-20: Medicare pays 100%

Days 21-100: \$185.50 per day

If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day. **Note: A stay in a skilled nursing facility is not long term custodial care.**

## Medicare Part B Benefits Medical

Part B of Medicare pays for a wide range of medical services and supplies. The medically necessary services of a doctor are covered whether the care is at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. Part B covered services include:

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

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

### What Do You Pay for Part B benefits?

Medicare Part B beneficiaries are responsible for paying a monthly premium, an annual deductible, and a coinsurance. 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 or through Easy Pay.

### Part B Costs (2021)

Standard monthly **premium** is \$148.50.

\*Beneficiaries with higher income (over \$88,000 for individuals; \$176,000 for married couples) will be responsible for higher premiums, known as the Income Related Monthly Adjustment Amount (IRMAA). Social Security determines whether each person is subject to IRMAA by looking at tax returns from 2-years prior; IRMAA is re-evaluated each year. For example, in 2021, SSA looks at your 2019 tax filings. You can request that SSA reconsider your IRMAA amount due to a life-changing event by submitting form SSA-44 (<https://www.ssa.gov/forms/ssa-44-ext.pdf>).

**Annual Deductible:** \$203

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

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

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

- **Medicare Supplement (Medigap) Insurance** helps Medicare beneficiaries pay their share of the costs not covered by Medicare. These policies fill in the “gaps” of Medicare.
- **Retiree/Union Benefits** may work with Original Medicare. Speak to your benefits administrator to understand the policy.
- **Medicaid or QMB** work to cover Medicare cost-sharing, as long as you meet eligibility requirements.

## How Much Can Providers Charge for Services?

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

- If a provider is a “**Participating**” provider, they will always accept the Medicare allowed amount as payment in full (Medicare pays 80% and the beneficiary pays 20%, after you meet the Part B deductible).
- A “**Non-Participating**” provider still has a relationship with the Medicare program; how this category differs from “Participating” providers is in how much they can charge to see a Medicare beneficiary. Non-participating providers can either “**accept assignment**” or “**not accept assignment**” on each claim. If you learn that a provider is Non-Participating, ask, “Will the doctor accept assignment for my claim?”
  - If a provider **accepts assignment**, he or she will accept Medicare’s approved amount for a service and will not charge you more than the 20% co-insurance (for most services), after you have met the Part B deductible.
  - If a provider does **not accept assignment**, the charges are subject to a “Limiting Charge,” which is an additional charge over the Medicare-approved amount. The Federal Limiting Charge is 15%. Some states, including NY, have lower limiting charges. For most physician services performed in NY, if the physician does not accept assignment, they can charge no more than 5% above what Medicare allows, with the exception of home and office visits, where they can bill up to the 15% Federal limiting charge.
- Providers who “**Opt Out**” of the Medicare program must enter a private written contract with any Medicare beneficiary who seeks their treatment. The provider will set a fee for each specific service and the patient agrees to pay the costs, understanding that **Medicare will not pay that doctor or reimburse the beneficiary**. A Medicare supplement policy (Medigap) will not pay any of these costs either. The Medicare beneficiary is still covered by Medicare for services of other providers.

## **Advance Beneficiary Notice of Non-Coverage**

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

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

## **Medicare Summary Notice**

A Medicare Summary Notice (MSN) will be mailed quarterly to each Medicare beneficiary for whom a Part A and/or Part B claim was submitted by a provider who accepts Medicare assignment. For claims from providers who do not accept Medicare assignment, a MSN will be mailed as the claims are processed, along with a check to the beneficiary for the 80%, if the beneficiary has already paid for the service.

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

Beneficiaries wishing to see their claims sooner can call 1-800-MEDICARE, or they can access their MSNs only by logging into <https://www.mymedicare.gov/>.

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

## **Medicare Appeals**

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

**For quality of care complaints** or if you feel your Medicare Part A or B services are ending too soon, such as that you are being discharged from the hospital too soon, call Livanta at 1-877-588-1123 (TTY: 1-855-887-6668). If you request an immediate review by Livanta, you will not be financially responsible for additional hospital charges until noon of the day following your receipt of Livanta’s review decision.

## MEDICARE PREVENTIVE SERVICES

Medicare covers nearly all preventive services at 100%, not subject to the Part B deductible and/or 20% coinsurance. You can get more information on Medicare's website, <https://www.medicare.gov/coverage/preventive-screening-services>.

Medicare provides coverage for the following preventive services:

**Annual Wellness Exam:** Once every 12 months after your first full year of Medicare Part B enrollment.

**"Welcome to Medicare" Preventive Visit:** Once within the first 12 months that you have Medicare Part B.

**Alcohol Misuse Screening and Counseling:** One screening per year. If provider recommended, up to 4 face-to-face visits per year with qualified Doctor.

**Abdominal Aortic Aneurysm Screening:** One-time screening ultrasound.

**Bone Mass Measurement:** Once every 24 months for those with certain medical conditions.

**Cardiovascular Disease Behavioral Therapy:** One visit per year.

**Cardiovascular disease Screening:** Once every 5 years.

**Cervical Cancer Screening (Pap Smear & Pelvic Exam):** Once every 24 months or every 12 months for those at risk.

**Colorectal Cancer Screening:** Frequently based on test for those age 50 and older. Ask your Doctor.

**Depression Screening:** One Screening per year done in a primary care setting that can provide follow up treatment and referrals.

**Diabetes Prevention Program:** Once per lifetime to help prevent type 2 diabetes.

**Diabetes Screening:** One to two per year based on risk factors.

**Diabetes self-management training:** Education for those with diabetes- Doctor must provide a written order.

**Flu Shot:** Once per flu season.

**Glaucoma Tests:** Once every 12 months for those at risk.

**Hepatitis B shot & screening:** Based on risk factors.

**Hepatitis C Screening:** one time for adults who do not meet the high-risk definition but were born from 1945-1965.

**HIV Screening:** Once every 12 months or up to 3 times per year during pregnancy.

**Lung Cancer Screening:** Once every 12 months for ages between 55-77, current smoker or quit smoking within the last 15 years.

**Mammogram screening:** Every 12 months for women age 40 and older.

**Medical Nutrition Therapy:** Three hours per year for the first year for people with diabetes, renal disease or a kidney transplant. Two hours per year after that.

**Obesity screening and counseling:** Counseling is covered for anyone found to have a BMI of 30 or more.

**Pneumonia shot:** Usually once in a lifetime. A second shot is now covered at least 11 months after the first shot.

**Prostate Cancer Screening:** Once every 12 months.

**Smoking and Tobacco Cessation:** up to 8 face to face visits per year.

**Sexually Transmitted Infection (STI) Screening and Counseling:** one every 12 months for those at risk.

## MEDICARE AS SECONDARY PAYER

When a person has Medicare and other health insurance coverage, it is necessary to understand which insurance is primary, and which is secondary. The primary insurance is the one that will consider the claim first and the secondary insurance will consider any balance after the claim has been paid or denied by the primary insurance.

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

**This chart shows who pays first in cases where someone has Medicare and insurance from a current employer:**

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

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

- **Working after age 65** - If there are 20 or more employees in the company where a Medicare beneficiary or spouse work, the EGHP is primary and Medicare is secondary. If there are fewer than 20 employees, then Medicare is primary and the EGHP is secondary.
- **Disability and Medicare:** If you have health insurance coverage based on your own, your spouse's or family member's active employment, for an employer of 100 or more employees, the EGHP is primary and Medicare is secondary. If there are fewer than 100 employees, then Medicare is primary and the EGHP is secondary.
- **End Stage Renal Disease (ESRD):** Some individuals are eligible for Medicare Part B coverage because they have End Stage Renal Disease and are either receiving maintenance dialysis treatments or have had a kidney transplant. If there is an EGHP (regardless of whether it is based on current employment), that coverage is primary during the first 30 months of Medicare eligibility. After 30 months, Medicare is primary.
- **Worker's Compensation and Medicare:** Worker's Compensation is usually primary in the event of a job-related injury and covers only health care expenses related to the injury. In cases where the Workers Compensation plan does not pay promptly, Medicare may make a conditional payment; Medicare would then be reimbursed when the payment comes through. The Benefits Coordination & Recovery Center (BCRC) assists with this function.
- **Liability Insurance and Medicare:** In situations of an accident or injury, the expenses of medical care may be covered by other types of insurance such as no-fault or automobile insurance, homeowners or malpractice policies. Since many liability claims take a long time to be settled, Medicare can make conditional payments for these cases to avoid delays in reimbursement to providers and liability to beneficiaries. Medicare will pay the claim and later seek to recover the conditional payments from the settlement amount.

**Retiree health coverage:** Generally speaking, in cases where one has both Medicare and retiree health insurance, Medicare is primary and retiree coverage is secondary. Some retiree benefits work more like a supplement to Original Medicare, while others act more like a Medicare Advantage plan. You must speak to the benefits administrator to understand how your retiree benefits coordinate with Medicare.



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

1. **FEHB and NO Part B.** Members can continue with their FEHB coverage without signing up for Medicare, which will save them the cost of the monthly Part B premium. If these members later decide they want Part B, they will need to wait until the next General Enrollment Period to sign up for Part B and will be subject to a late enrollment penalty in the form of a higher monthly Part B premium.
2. **FEHB and Part B.** Members can continue with their FEHB coverage and also enroll in Part B. Some FEHB plans may provide an incentive to enroll in Medicare, such as reducing out-of-pocket costs and waiving FEHB plan co-payments, deductibles, and coinsurance. Members electing to participate in both Medicare and FEHB will need to pay both the FEHB and Part B premiums.
3. **Part B and NO FEHB.** Unlike most retirees, Federal retirees can SUSPEND (not cancel) their retiree coverage to enroll in a Medicare Advantage plan, which may have a lower monthly premium or no added premium at all. Individuals choosing this option will still need to enroll in Part B in order to enroll in a Medicare Advantage plan, but they will avoid the higher cost of the FEHB premium. Additionally, they may elect to return to FEHB coverage during the next FEHB Open Enrollment period.

Visit the Office of Personnel Management (OPM) website for more information about Medicare and FEHB at:

<https://www.opm.gov/healthcare-insurance/fastfacts/fehbmedicare.pdf>  
Or <https://www.opm.gov/healthcare-insurance/healthcare/medicare/75-12-final.pdf>

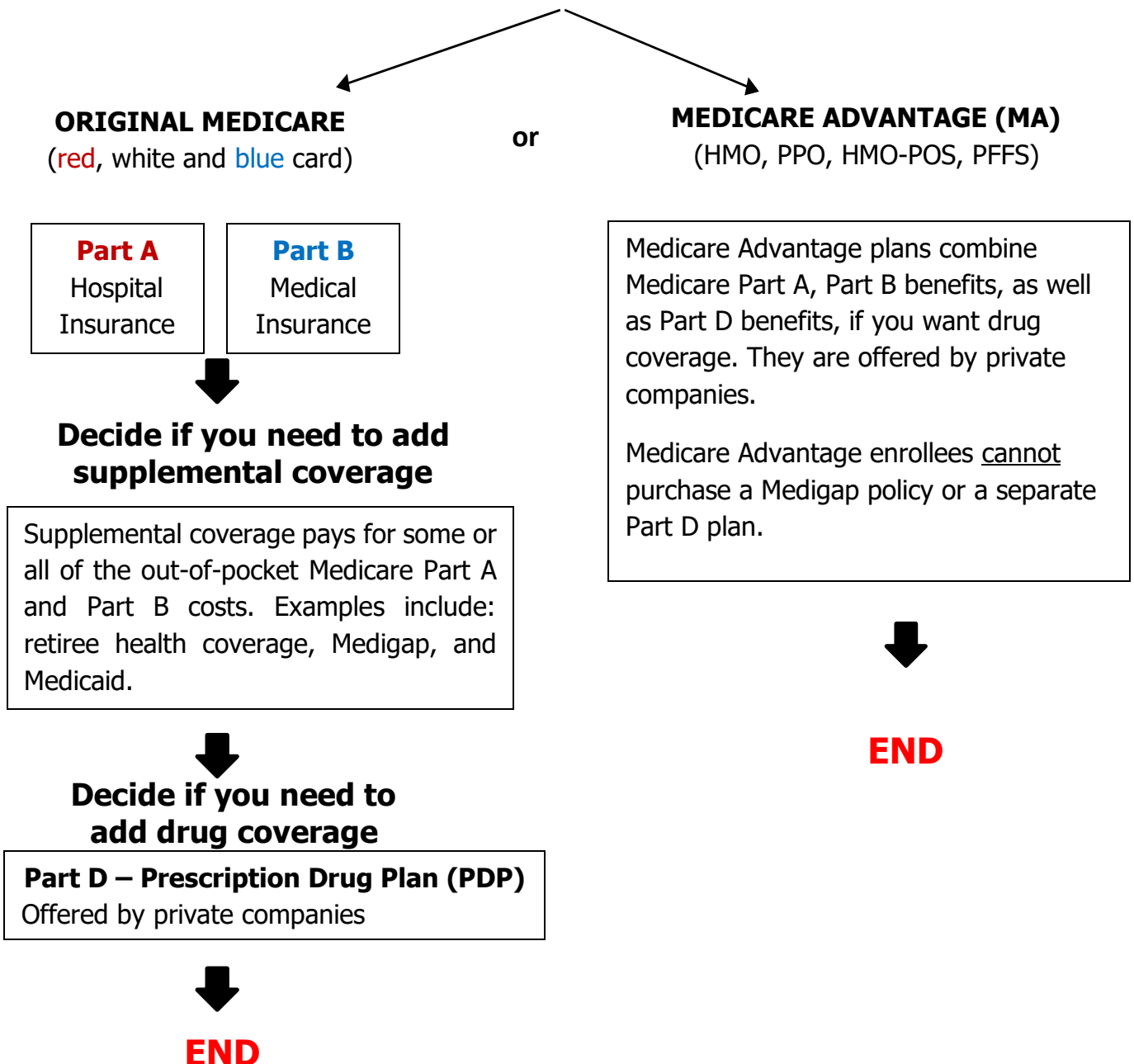
## Choices in the Medicare Program

Medicare beneficiaries have a choice in how they receive their Medicare benefits. They can either receive Original Medicare, in which they use their red, white and blue Medicare card for all Part A and Part B covered services, they may also choose a supplement and a Part D plan **OR** they can receive their Medicare benefits through a Medicare Advantage plan (Part C), in which a private company provides them with all Medicare benefits.

### MEDICARE COVERAGE CHOICES

**Everyone with Medicare has choices in how they get their Medicare coverage. There are two main ways to get your coverage – Original Medicare or a Medicare Advantage Plan. Below is a decision tree to help guide your decision-making.**

**Decide how you want to get your coverage**



## MEDICARE SUPPLEMENT INSURANCE (Medigap)

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

### FAQS

#### **Why should I consider a Medigap policy?**

A Medigap policy offers coverage for out-of-pocket health service costs after Medicare, which are the beneficiary's share of costs. For example, a Medigap policy might cover the Part A deductible, the Part B outpatient co-insurance of 20% of allowed charges, and other costs.

#### **What Medigap policies are available?**

There are ten standard Medigap policies available, designated "A" through "N." Each of the policies covers the basic benefit package, plus a combination of additional benefits.

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

#### **When can I enroll in a Medigap policy?**

In New York State, you can purchase a Medigap policy at any time when you are enrolled in Medicare. You are guaranteed the opportunity to purchase a policy even if you are under age 65 and have Medicare due to disability. Your Open Enrollment Period is the first 6 months you are eligible for part A and Part B.

#### **When can I switch Medigap policies?**

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

#### **How do I choose a Medigap policy?**

Since Medigap plans are standardized, you first need to decide the level of coverage you need. Once you establish which set of benefits is right for you, you can compare the premium, service and reputation of the insurance companies.

\*Current rates and plan availability can be found at the Department of Financial Services.

[https://www.dfs.ny.gov/consumers/health\\_insurance/supplement\\_plans\\_rates](https://www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates)

Use the Department of Financial Services Portal to find rates for plans available in your zip code.

<https://myportal.dfs.ny.gov/web/guest-applications/medicare-monthly-premiums>

#### **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. You can switch Medigap policies whenever you need a different level of coverage. For example, when your health needs are greater, you can arrange to purchase a Plan G, if you find plan B is too limited. The new Medigap policy would replace the previous one.

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

The maximum period that a Medigap policy's coverage can be denied for a pre-existing health condition is the first six months of the new policy and only for those claims that are directly related to that condition and only if you have had a break in coverage for more than 63 days and did not enroll during your Supplemental Open Enrollment period.

\* A pre-existing condition is a condition for which medical advice was given, or treatment was recommended by, or received from, a physician within six months before the effective date of coverage. You may qualify for **immediate** coverage for a pre-existing health condition if **(1)** you buy a policy during your open enrollment period, the first 6 months you are eligible for Medicare or **(2)** if you were covered under a previous health plan for at least six months without an interruption of more than 63 days. If your previous health plan coverage was for less than six months, your new Medigap policy must credit you for the number of months you had coverage. Some insurers have shorter wait periods for pre-existing conditions but the wait period cannot be longer than 6 months.

## STANDARD MEDIGAP PLANS

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

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

- Coverage for the **Part A copayment** amount (\$371 per day in 2021) for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for the **Part A copayment** amount (\$742 per day in 2021) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for Medicare Part A **hospice care** cost-sharing.
- Coverage under Medicare Parts A and B for the reasonable cost of the **first 3 pints of blood**
- Coverage for the **coinsurance amount for Part B services** (generally 20% of approved amount), after the annual deductible is met (\$203 in 2021).

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

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

**PLAN C<sup>1</sup>** includes the **basic benefit, plus**

- Coverage for the Medicare Part A **inpatient hospital deductible**.
- Coverage for the **skilled nursing facility care copayment** amount (\$185.50 per day for days 21 through 100 per benefit period in 2021).
- Coverage of the **Medicare Part B deductible** (\$203 per calendar year in 2021).
- 80% coverage for medically necessary **emergency care in a foreign country**, after a \$250 deductible and \$50,000 lifetime maximum benefit.

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

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

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

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

**PLAN F+ (high deductible)**

- Same benefits as the Standard Plan F, but you will have to pay a **\$2,370 deductible** in 2021 before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums.

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

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

**PLAN G+ (high deductible)**

- Same benefits as the Standard Plan G, but you will have to pay a **\$2,370 deductible** in 2021 before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums. While Plan G does not cover the Part B deductible, the amount that you pay towards the deductible is credited towards the G+ deductible.

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

- Coverage for **50%** of the Medicare Part A **inpatient hospital deductible**.
- Coverage for **50%** of **Part B coinsurance** after you meet the yearly deductible for Medicare Part B, but 100% coinsurance for Part B preventive services.
- Coverage for 100% of the **Part A copayment** amount for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the **Part A copayment** amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for **50% hospice cost-sharing**.
- Coverage for **50%** of Medicare-eligible expenses for the **first 3 pints of blood**.
- Coverage for **50%** of the **skilled nursing facility** care daily copayment amount.
- [Annual out of pocket limit of \\$6,220 in 2021.](#)

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

- Coverage for 75% of Medicare Part A inpatient hospital deductible.
- Coverage for 75% of Part B coinsurance after you meet the yearly deductible for Medicare Part B, but 100% coinsurance for Part B preventive services.
- Coverage for 100% of the Part A copayment amount for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A copayment amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for 75% hospice cost-sharing.
- Coverage for 75% of Medicare-eligible expenses for the first 3 pints of blood.
- Coverage for 75% of the skilled nursing facility care daily coinsurance amount.
- [Annual out of pocket limit of \\$3,110 in 2021.](#)

**Plan M** includes the **basic benefit, plus**

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

**Plan N** includes the **basic benefit, plus**

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

\*Current rates and plan availability can be found at the Department of Financial Services.

[https://www.dfs.ny.gov/consumers/health\\_insurance/supplement\\_plans\\_rates](https://www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates)

Use the Department of Financial Services Portal to find rates for plans available in your zip code.

<https://myportal.dfs.ny.gov/web/guest-applications/medicare-monthly-premiums>

## Medicare Advantage (Part C)

Medicare Advantage plans provide beneficiaries with alternatives to Original Medicare. Medicare Advantage plans are offered by private companies and include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPO), HMOs with Point-of-Service option (HMO-POS), Private Fee for Service (PFFS) and Special Needs Plans (SNP). The companies that offer Medicare Advantage plans contract with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare benefits to enrollees. Medicare Advantage plans provide all Medicare Part A and Part B benefits and often Part D drug coverage, as well as some other optional benefits, like dental. If someone joins a Medicare Advantage plan, they will have Medicare coverage through that private plan, not through "Original Medicare."

**To be eligible to join a Medicare Advantage plan**, you must have both Medicare Part A and Part B; you must live in the plan's service area; and you cannot have end stage renal disease (ESRD). (Beginning in 2021, people with ESRD will also be eligible to join Medicare Advantage plans.) A Medicare Advantage plan cannot turn away an applicant because of health problems (or impose a waiting period for pre-existing conditions), other than ESRD.

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

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

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

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

**PPOs** provide a network of health care providers and hospitals but do not restrict the enrollee from going out-of-network. The PPO sets its payment to in-network providers with a fixed co-pay from the enrollee; enrollees will pay more for services from out-of-network providers.



**HMO-POS** Provide more flexibility than an HMO because members may use both in-network and out-of-network providers at certain points of service. However, HMO-POS plans may not cover all benefits out-of-network. For example, out of network may be covered at 50%.

**Special Needs Plans (SNP)** are Medicare Advantage plans that are available only to certain groups of people with Medicare. In Chemung County currently, only people with both Medicare and Medicaid or QMB and people living in a nursing home can purchase these policies. Coverage includes services covered by Medicare Parts A and B, as well as Part D prescription drug coverage. SNPs may also provide additional services that may be needed by the specific population to which they are geared. Eligible people with Medicare can join a SNP at any time.

**Enrolling in a Medicare Advantage Plan** can be done when first Medicare eligible during the Initial Coverage Election Period (ICEP). Enrollment can be done online at <https://www.medicare.gov/>, by calling 1-800-MEDICARE, or by contacting the plan directly, your HIICAP counselor may also be able to assist you.

- For most people, the ICEP is the 7-months surrounding the month in which you are first Medicare eligible.
- Beneficiaries that delay Part B enrollment will have their ICEP in the months prior to Part B enrollment.

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

In addition, the Medicare Advantage Open Enrollment period is also open to all beneficiaries in Medicare Advantage plans at the beginning of the year, from January 1 – March 31. They can switch to a different Medicare Advantage plan or return to original Medicare, with the change effective the first of the following month, either February 1, March 1, or April 1. To make this change, simply enroll in the plan you want; this enrollment will automatically disenroll you from the other Medicare Advantage plan.

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

**Annual Election Period (AEP):** aka Open Enrollment, from October 15-December 7, you can change your Medicare Advantage plan **or** return to Original Medicare with or without a Part D plan, with the change effective January 1.



**Other Special Enrollment Periods (SEP) may be available based on your circumstance**, for example individuals with Medicaid, a Medicare Savings Program or Extra Help can switch plans once a quarter during the first nine months of the year (January – March; April – June; July – September), with the change effective the first of the following month. Individuals can change to either a different Medicare Advantage plan or to Original Medicare with a Part D plan.

### **Tips for Switching Between Original Medicare and Medicare Advantage**

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

### **Medicare Advantage Appeals**

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

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

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

**For quality of care complaints** or if you feel your Medicare Part A or B services are ending too soon, such as that you are being discharged from the hospital too soon, call Livanta at 1-877-588-1123 (TTY: 1-855- 887-6668). If you request an immediate review by Livanta, you will not be financially responsible for additional hospital charges until noon of the day following your receipt of Livanta's review decision.

## Frequently Asked Questions about Medicare Advantage Plans

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

Each Medicare Advantage plan sets its own premiums and cost sharing schedule. You may pay a monthly premium directly to the plan, which is in addition to the monthly Medicare Part B premium. There may also be co-pays, co-insurance and deductibles for health services.

All Medicare Advantage plans are required to have annual maximum out-of-pocket costs for all Part A and Part B covered services, which limits how much you will have to pay out-of-pocket in a given calendar year. In 2021, maximum out-of-pocket costs (MOOP) cannot exceed \$7,550 in-network and \$11,300 out-of- network.

### What about emergency services?

Emergency medical care will be covered by the Medicare Advantage plan provided that you follow its requirements for notifications and approval.

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

1. **Your doctors' participation in the plan:** Ask your doctors what plans they participate in. Even if you already have an established relationship with that doctor, you should confirm provider participation.
2. **Preferred hospital(s) participation in the plan:** Make sure that any hospitals you use, and any that you would like to have access to, participate in the plan, or would allow you to access the hospital on an out-of-network basis.
3. **Prescription drugs:** Check how the plan would cover your prescription drugs (formulary, restrictions, cost) by using the Medicare.gov Planfinder <https://www.medicare.gov/plan-compare/#/?lang=en>
4. **Finances:** Receiving care through a Medicare Advantage plan may cost you less than receiving care through Original Medicare. Medicare Advantage plans may cover services which are not covered by original Medicare, such as routine vision and dental care, as well as hearing aids. It is important to research the fee structure (premium, copays, deductible, maximum out-of-pocket costs, etc.) in a Medicare Advantage plan before enrolling.
5. **Geographic Location:** It is important to think about your travel plans when deciding whether an HMO plan is right for you. Because HMO plans have defined geographic areas that they serve, if you plan to be outside of the service area for any length of time, an HMO may not be right for you, since only emergency care is covered outside the plan's service area. The service areas of PPO and HMO-POS plans are less restrictive, but you should still be aware of the plan's service area.

### 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 will need to cancel your Medigap policy.

## MEDICARE PART D – PRESCRIPTION DRUG COVERAGE

**Medicare Part D is prescription drug coverage offered through private insurance companies to help cover the cost of prescription drugs.**

Medicare prescription drug plans are available to all people with Medicare (Part A and/or Part B). Part D is an optional benefit; Medicare beneficiaries are not required to join a plan, although there may be a penalty if you don't join when you're first eligible.

Medicare Part D is only offered through private companies who have entered into a contract with the federal government to provide Medicare Part D drug coverage to Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) regulates the plans and categories of covered drugs. Each Part D plan has its own list of covered medications (formulary) and participating pharmacies.

Medicare Part D is offered in one of two ways:

1. **Stand Alone Prescription Drug Plans (PDPs):** these plans work with Original Medicare and only cover prescription drugs.
2. **Medicare Advantage Prescription Drug Plans (MAPDs):** these are plans such as HMOs, PPOs, HMO-POS, or SNPs, which offer comprehensive benefits packages that cover all of the following: hospital, doctors, specialists, and prescriptions. If you are in a Medicare Advantage plan and want to have Part D coverage, you typically will get Part D coverage through your Medicare Advantage plan.

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

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

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

- **Deductible** (up to \$445). This is the amount that you have to pay out-of-pocket before your plan helps pay for the cost of your drugs. Some plans have a lower deductible or no deductible.
- **Initial Coverage Level** You pay a fixed copay of up to 25% of drug costs up to \$4,130 in total drug costs. (Total drug costs include the amount that you pay for the drug plus the amount that the plan pays for the drug.)
- **Coverage Gap** After \$4,130 in total drug costs, you pay 25% of brand name and generic drug cost, until you have incurred \$6,550 in out-of-pocket costs. This includes the deductible (if any) plus any co-payments or coinsurance paid while

reaching the coverage gap, the entire cost of brand name drugs purchased in the coverage gap, and the out-of-pocket costs for generic drugs purchased in the coverage gap.

- **Catastrophic Coverage** (after \$6,550 in out-of-pocket expenses). The beneficiary is responsible for the greater of five percent (5%) of drug costs or a copay of \$3.70 for generic medications and \$9.20 for brand-name drugs.

### **Enrollment in Medicare Part D**

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

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

There are also limited exceptions where a beneficiary may have a **Special Enrollment Period (SEP)** to enroll in a Part D plan or to switch plans outside of the AEP. These can include the following situations:

- Individuals with Medicaid, a Medicare Savings Program or Extra Help can switch plans once a quarter during the first nine months of the year (January – March; April – June; July – September), with the change effective the first of the following month.
- EPIC members can change Part D plans once in a calendar year.
- January 1 – March 31, if you are in a Medicare Advantage plan with Part D, you can make a change to either a different Medicare Advantage plan, or to Original Medicare with or without Part D drug coverage.
- Change in county of residence where one has new Part D plan choices.
- Individuals entering, residing in, or leaving a long-term care facility, including skilled nursing facilities.
- Individuals disenrolling from employer/union-sponsored coverage, including COBRA, to enroll in a Part D plan.

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

- Online at <https://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.

### **Late enrollment penalty**

- Even if a person with Medicare does not currently use a lot of prescription drugs, he or she should still consider purchasing a Part D plan. If a beneficiary does not have creditable drug coverage (coverage that is at least as good as the standard Medicare prescription drug coverage), they will have to pay a late enrollment penalty if they choose to enroll later. This penalty needs to be paid for as long as you have Part D coverage. If the beneficiary has had creditable coverage with a gap of no more than 63 days from when that coverage ended and the Medicare

Part D coverage begins, they will not be subject to a penalty. There is no late enrollment penalty for people with full or partial Extra Help.

- Anyone who enrolls in Part D during their Initial Enrollment Period (IEP) will not incur a late enrollment penalty. Other people with creditable coverage, such as through a former employer or union, the Veterans Administration (VA), or TRICARE for Life, will not have a penalty for late enrollment.

## FAQs

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

You may not need to enroll in a Part D plan if you have creditable drug coverage through a current or former employer. The current or former employer should advise you, usually through a letter, as to whether your drug coverage is “creditable” and whether or not you should enroll in a Part D plan. If you do not receive a letter, contact the employer to determine if you should enroll in a Part D plan. This is important, enrollment in a Part D plan may compromise **all** health benefits through the employer plan, not just prescription drug coverage.

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

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

### **How do I select a Part D plan?**

To select a Part D plan, it is best to use the Planfinder tool at <https://www.medicare.gov/>

You can log in using your Medicare account username and password, or do a general search where you do not enter identifying information.

Follow the Planfinder prompts, enter all of the medications you are currently taking or expect to take in the upcoming year, along with the dosages and quantities needed.

You will be asked to select up to three pharmacies if you'd like to compare costs, one of these could be a mail order option. After you have entered all of the information, the plan finder will allow you to select which plans you would like to view— either Part D plans that work with Original Medicare, or Medicare Advantage Plans. You can use various tools to filter the search results. It is important to look at the details of each plan to understand what restrictions, if any, may apply. You can contact the plan to verify the information if you have questions.

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

## Cost utilization management tools

In an effort to control costs, Medicare prescription drug plans employ the following cost utilization management tools

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

## Part D Appeals

Part D appeals follow the same process regardless of whether you have coverage in a Stand-Alone Part D Plan (PDP) or a Medicare Advantage plan. If a plan won't cover a drug you think you need, or if the plan will cover the drug, but at a higher price than you think you should pay, you can:

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

## Extra Help with Drug Plan Costs for People with Limited Incomes

The Social Security Administration (SSA) can subsidize the cost of a Part D plan for Medicare beneficiaries with lower incomes and limited resources. The program is called the **Low-Income Subsidy Program (LIS), also known as Extra Help**. People with Medicaid and/or a Medicare Savings Program (MSP) are automatically enrolled in Full Extra Help; you can also apply directly through SSA for Extra Help.

**Full Extra Help** is for beneficiaries with monthly incomes up to 135% of the Federal Poverty Level, and asset limits within the amounts stated below.

### Benefits of Full Extra Help:

- No monthly premium for a Part D plan, as long as the plan selected is a “benchmark” plan, a Basic plan that has a monthly premium that is fully subsidized by Extra Help (monthly premium up to \$42.27 in 2021).
- No deductible.
- Reduced co-pays, depending on income - beneficiaries with incomes up to 100% of the Federal Poverty Level will have co-pays of \$1.30 for generic and \$4.00 for brand name prescriptions. All others with full Extra Help will have co-pays limited to \$3.70 for generic and \$9.20 for brand name prescriptions.

**Partial Extra Help** is for beneficiaries with monthly incomes up to 150% of the Federal Poverty Level and asset limits within the amounts stated below.

### Benefits of Partial Extra Help:

- Monthly plan premium on a sliding scale based on income.
- Deductible reduced to not more than \$92 (2021).
- Reduced co-pays – pay the lower of 15% of drug costs or the plan’s cost-sharing.

<b>Extra Help Income and Asset Limits (2021)</b>				
	<b>Individual</b>		<b>Married Couple</b>	
	Monthly Income	Assets	Monthly Income	Assets
<b>Full Extra Help</b>	\$1,456	\$9,470	\$1,960	\$14,960
<b>Partial Extra Help</b>	\$1,615	\$14,790	\$2,175	\$29,520

HIICAP counselors can help screen for eligibility for Extra Help. To apply for Extra Help, call SSA at 1-800-772-1213 (1-800-325-0778 TTY), or apply online at <https://www.ssa.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.

There are cases where someone is automatically eligible for Extra Help but is not enrolled in a Part D plan. LINET is the program designed to help these cases.

The **Limited Income Newly Eligible Transition (LINET) Program** LINET can get you retroactive or temporary prescription drug coverage while you enroll in a Part D plan. You may need documentation that you are eligible for Extra Help, such as a Medicaid award letter, a MSP award letter, or proof of SSI. **LINET** can be reached at 1-800-783-1307.



## NEW YORK STATE EPIC PROGRAM (Elderly Pharmaceutical Insurance Coverage)

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

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

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

### EPIC FEE AND DEDUCTIBLE PLANS

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

**EPIC's Fee Plan** is for individuals with annual incomes up to \$20,000 and married couples with incomes up to \$26,000. To participate in the Fee Plan, participants pay the annual fee associated with their income, set on a sliding scale. Fees are based on the **previous year's** annual income and are paid quarterly. After paying the fee, participants pay the EPIC co-pay for their medications, based on their Part D plan's deductible and cost-sharing.

EPIC pays the Part D monthly premium for Fee Plan members (premium assistance), up to \$42.27 per month in 2021. In addition, EPIC members with full Extra Help will have their EPIC fees waived.

**EPIC's Deductible Plan** is for individuals with annual incomes between \$20,001 and \$75,000, and married couples with incomes between \$26,001 and \$100,000. To participate in the Deductible Plan, participants pay for their prescriptions until they meet their EPIC deductible amount, which is based on the **previous year's income**. After meeting the deductible, participants pay only the EPIC co-pay.

There is no fee to join the deductible plan.

### Deductible with premium assistance

EPIC pays the Part D monthly premium (up to \$42.27 per month in 2021, premium assistance) for Deductible Plan members with incomes up to \$23,000 single/\$29,000 married.



## Reduced Deductible

Deductible plan members with higher incomes must pay their own Part D premiums, but their EPIC deductible will be lowered by the annual cost of a basic Part D plan (\$507 in 2021).

\*Drug costs incurred in the Part D deductible phase cannot be applied to the EPIC deductible.

### \*TIPS\*

- ✓ EPIC members without Extra Help may want to look into a Part D plan without a deductible or a lower deductible; EPIC does not cover prescription medications purchased during a Part D plan's deductible period.
- ✓ EPIC enrollment and EPIC copays are not reflected in the <https://www.medicare.gov/Planfinder> tool.

### How does EPIC work with Medicare Part D?

- New York law requires EPIC members to also be enrolled in a Medicare Part D plan so if someone cannot enroll in Part D for whatever reason, they are not eligible for EPIC.
- You can enroll in EPIC at any time of the year. Even if you do not have a Part D plan at the time of EPIC enrollment, you can enroll in a Part D plan after you become an EPIC member.
- Part D coverage is primary and EPIC coverage is always secondary.
- The enrollee pays the EPIC co-pay based on the amount remaining after the Part D plan pays, thus reducing the enrollee's costs. **See chart below.**
- In addition, EPIC will cover you after you have met any Part D deductible, including during the initial coverage level, the coverage gap, and during catastrophic coverage, as long as the drugs are first covered by your Part D plan.
- EPIC will be a secondary payer for Part D plan members who use EPIC **participating** mail order pharmacies, even if that mail order pharmacy is outside of NY State. (EPIC will not pay the out-of-state pharmacy for a drug not covered by the Part D plan.)

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

## EPIC and Extra Help

EPIC requires members who appear to be income eligible for Extra Help to complete an additional form called Request for Additional Information (RAFI) so that EPIC can apply to the Social Security Administration for Extra Help on their behalf. The application for Extra Help will then be forwarded to New York State's Medicaid program to assess eligibility for a Medicare Savings Program to help pay for the Medicare Part B premium.

### EPIC and Employer/Retiree Drug Coverage

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

\*\*EPIC is New York State's **State Pharmaceutical Assistance Program (SPAP)**. SPAP members have a Special Enrollment Period (SEP), which allows you to enroll in or switch Part D plans (either a Medicare Advantage plan with Part D coverage, or a Part D plan that works with Original Medicare) one additional time each year outside of the Open Enrollment period.

## Applying for EPIC

- You can call EPIC at 1-800-332-3742 (TTY: 1-800-290-9138) to request an application.
- Visit <https://www.health.ny.gov/forms/doh-5080.pdf> for more information on EPIC and to download and print an application. You can also submit an online request for EPIC to mail you an application. There is not an option at this time to complete an EPIC application online.
- Fax the completed EPIC application to 518-452-3576, or mail the completed application to EPIC, P.O. Box 15018, Albany, NY 12212-5018.
- You must be 65 to be eligible for EPIC. EPIC will reject applications that are sent in too early, you must wait until you are 65 to apply.

## MEDICARE SAVINGS PROGRAMS

Medicare Savings Programs (MSP) can help eligible individuals pay for their Medicare premiums and other costs associated with Medicare. MSPs are administered by Medicaid in the Department of Social Services (DSS). One can apply for the Medicare Savings Program at any time of the year. MSPs are authorized for 12-months; DSS mails renewal packets annually to assess ongoing eligibility.

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

<b>MSP Monthly Income and Resource Limits - 2020</b>				
	<b>Single</b>		<b>Married Couple</b>	
	Income	Resources	Income	Resources
<b>QMB: 100% FPL</b>	\$1,084	No Limit	\$1,457	No Limit
<b>SLMB:120% FPL</b>	\$1,296	No Limit	\$1,744	No Limit
<b>QI: 135% FPL</b>	\$1,456	No Limit	\$1,960	No Limit

<b>MSP Monthly Income and Resource Limits – 2021</b>				
	<b>Single</b>		<b>Married Couple</b>	
	Income	Resources	Income	Resources
<b>QMB: 100% FPL</b>	\$1,094	No Limit	\$1,472	No Limit
<b>SLMB:120% FPL</b>	\$1,308	No Limit	\$1,762	No Limit
<b>QI: 135% FPL</b>	\$1,469	No Limit	\$1,980	No Limit

## Applying for a Medicare Savings Program

### What application do I use?

- If you are applying for an MSP only (not Medicaid and an MSP), you can use the simplified Medicare Savings Application form, the DOH-4328, at <https://www.health.ny.gov/forms/doh-4328.pdf>
- If you are applying for both an MSP and Medicaid, use the Access NY Health Care, DOH-4220 application found at <https://www.health.ny.gov/forms/doh-4220.pdf> and Supplement A <https://www.health.ny.gov/forms/doh-5178a.pdf> both forms must be completed for anyone over 65 or disabled. Indicate to Department of Social Services that you wish to be assessed for the MSP program.

### What counts as income when applying for an MSP?

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

**Note:** The MSP program requires that you be collecting any Social Security benefits for which you are eligible and maximizing any other income you may be eligible for including distributions from retirement accounts.

### Medicare Savings Program tips:

- Individuals in an MSP are automatically eligible for full Extra Help to lower their Medicare Part D drug costs.
- If you apply for Extra Help through the Social Security Administration, SSA will forward your information to New York State to be considered for MSP eligibility.
- You may qualify for a Medicare Savings Program even if still working due to earned income disregards.

Your HIICAP counselor can help you determine if you may be eligible, understand what income is countable and assist you with applying.

## MEDICARE FRAUD AND ABUSE

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

### **What is Fraud?**

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

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

### **What is Abuse?**

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

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

### **Medicare Do's and Don'ts**

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

**Be alert to:**

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

**How to report Medicare fraud**

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

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

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

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

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

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

**IDENTITY THEFT**

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

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

## MEDICAID ELIGIBILITY FOR 65+, BLIND OR DISABLED

Medicaid is a joint federal, state and local government health insurance program for low-income individuals. Medicaid is a “means tested” program requiring applicants to prove financial need in order to be eligible.

### MEDICAID COVERED SERVICES

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

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

- **Community Medicaid** refers to Medicaid that people use when they are living in their home and using Medicaid for health insurance coverage.
- **Institutional (Chronic) Medicaid** refers to Medicaid providing the full range of health coverage AND paying for care in a nursing home on a full-time basis (this is different from care in a skilled nursing facility, which is temporary and covered by Medicare Part A).

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

Medicaid counts **income** from all sources, including wages, Social Security, pension payments and worker’s compensation. 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 spenddown your “excess income,” the amount by which you are over Medicaid’s income limit, on health expenses and then you have full Medicaid coverage for the remainder of the month.

**Assets** include cash, bank accounts, IRAs and stocks. Certain assets are not counted toward these limits, including your primary home, your automobile and personal belongings. Community Medicaid applicants must document assets in the month of application; there is no lookback period for transfer of assets for Community Medicaid.

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.

**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/forms/doh-4220.pdf> and <https://www.health.ny.gov/forms/doh-5178a.pdf>

### **Where do I submit the application?**

If you live in Chemung County, Department of Social Services, 425 Pennsylvania Ave, PO Box 588, Elmira NY 14902.

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

### **Eliminating the "Spenddown" for Medicaid Applicants**

Disabled individuals of any age with community Medicaid services including home care, adult day care and prescription drug costs can utilize all of their income to pay for living expenses by participating in a **supplemental needs trust**. Setting up a supplemental needs trust eliminates the need for individuals to contribute their "surplus" or "spenddown" moneys to Medicaid. The pooled-income trust fund, managed by a nonprofit agency, receives the individual's monthly surplus income and redistributes it on behalf of that individual as directed by the individual or their legal representative.

\*Contact your HIICAP counselor for more information. Find a list of trusts at <http://www.wnylc.com/health/entry/4/>

### **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 is secondary. In addition to paying for Medicare's cost-sharing requirements, such as the Part A deductible and Part B deductible and 20% co-insurance, Medicaid in New York also offers benefits, such as home health care, and dental and vision services, which are not covered under the Medicare program.

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

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

### **How does Medicaid interact with Medicare Part D?**

Dual eligibles are automatically enrolled in full Extra Help for their drug costs and will be automatically enrolled in a Part D plan if they do not sign up for one on their own. As long



as a dual eligible is enrolled in a Part D plan that is classified as a “benchmark” plan, he/she will pay no premium for Part D coverage. Dual eligibles with incomes under 100% of the Federal Poverty Level (FPL) will have co-pays of \$1.30 for generic/\$4.00 for brand name prescriptions in 2021. Those with incomes over 100% FPL will have co-pays of \$3.70 for generic/\$9.20 for brand name prescriptions.

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

## **Mandatory Medicaid Managed Long Term Care:**

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

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

1. Call New York Medicaid Choice at 855-222-8350 to request a CFEEC appointment. CFEEC, the Conflict Free Evaluation and Enrollment Center, evaluates the need for home care services for people newly in need of long term care services. If CFEEC determines that the client needs long term care services, defined as 120+ days of home care within a year, the client must enroll in a managed long-term care plan for at least their home care services. Find more info at, <https://icannys.org/icanlibrary/need-long-term-care-what-you-should-know-about-the-cfeec/>
2. If you are approved for Medicaid covered long term care, you will be required to enroll in a Medicaid Managed Long Term Care plan. You will receive a packet in the mail from New York Medicaid Choice, <https://nymedicaidchoice.com/> **1-888-401-6582**, telling you about your choices and how to enroll. You will have 60 days to enroll in a plan. If you don't select a plan for yourself, you will be automatically enrolled in a Managed Long Term Care plan.
  - **Managed Long Term Care (MLTC):** MLTC plans provide long term care services, as well as a few other services, non-emergency medical transportation, podiatry, audiology, dental and optometry. This is the most flexible of the managed long-term care plan options, as you can maintain your current Medicare and Medicaid provider arrangements. MLTC enrollees will continue to use their current plan (i.e. your Medicare card, your Medicaid card, or your Medicare Advantage card) for all other Medicare and Medicaid services. Individuals who do not enroll in a managed long-term care plan on their own will be automatically enrolled into an MLTC plan.

### **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 managed long term care plan. If a member does not pay the spenddown, the plan can disenroll the member.

### How do I select a plan?

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

### How will the plan determine how many hours of home care I will receive?

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

### What if I want to switch managed long term care plans?

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

### 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 and mainstream Medicaid (with long-term care services). ICAN can be reached at 1-844-614-8800.

**MEDICAID FOR INSTITUTIONAL CARE (Chronic Medicaid):** Income and asset guidelines are stringent for institutional Medicaid. Generally speaking, for nursing home residents, most of one's income will go toward the cost of the nursing home, except for a small monthly "personal needs" allowance, unless they are expected to return home. Rules are more flexible if there is a spouse still living in the home.

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

**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.

For more information on using Medicaid to pay for a Nursing Home Stay, please see Chemung County Department of Aging's document,

'Using Medicaid to Pay for a Nursing Home Stay'

<https://cms5.revize.com/revize/chemungcounty/USING%20MEDICAID%20TO%20PAY%20FOR%20A%20NURSING%20HOME%20STAY.pdf>

# NY STATE OF HEALTH/HEALTH INSURANCE EXCHANGE

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

The Health Insurance Exchange is an organized marketplace for purchasing health insurance. In New York State, the Exchange is known as New York State of Health. Marketplace plans offer comprehensive health coverage, and have a cost sharing structure that can include premiums, deductibles, copayments, and maximum out-of-pocket costs.

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

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

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

## How to apply for coverage through the Marketplace:

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

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

## How does other insurance interact with Marketplace plans?

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

- If you are receiving Social Security Disability Insurance (SSDI) and are in the 24-month waiting period for Medicare coverage to begin, you may want to look into a Marketplace plan. When you become Medicare eligible, you can drop your Marketplace plan.

### **MEDICAID FOR PEOPLE UNDER 65, NOT BLIND OR DISABLED**

Pregnant women, children up to age 18, parents/caretaker relatives, and childless adults ages 19-64 are evaluated for Medicaid eligibility under MAGI (Modified Adjusted Gross Income) budgeting. Those with incomes up to 138% FPL may qualify for Medicaid. Medicaid recertification happens annually. You must respond to mailings in order to be evaluated for ongoing Medicaid benefits.

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

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

Individuals with Medicaid through the Marketplace cannot maintain Marketplace coverage when they turn 65 or get Medicare due to disability, though the transition process differs depending on whether you get Medicare due to age or disability. **Exception: Parents/Caretaker relatives of minor children are allowed to maintain Medicaid through the NY State of Health and also have Medicare.** All individuals who transition from Marketplace Medicaid to Medicare will automatically receive Extra Help for Part D for a period of time.

- **Medicare eligible at 65:** As you approach 65, your Medicaid case is transferred to the Department of Social Services (DSS) from the NY State of Health. DSS will mail forms to be completed to assess whether you can remain on Medicaid at the lower, non-MAGI income levels. You should respond to any DSS mailings if you wish to be assessed for ongoing Medicaid eligibility. If ongoing Medicaid eligibility is denied, you may want to consider joining a Medicare Advantage plan or purchasing a Medigap policy if in Original Medicare. Individuals will have full Extra Help for the remainder of the calendar year.
- **Medicare eligible due to disability:** After receiving 24 months of Social Security Disability Insurance (SSDI) payments, individuals become Medicare eligible and are automatically sent a Medicare card. The individual will maintain Medicaid coverage through the end of their 12-month Medicaid authorization period; they will still have Medicaid through the Marketplace, but will use their Medicaid card to access health services. Medicare is their primary health insurer, and Medicaid is their secondary insurance. As their 12-month authorization period comes to an end, the Medicaid case gets transferred from NY State of Health to DSS. DSS will mail forms to evaluate for ongoing Medicaid eligibility. It is advised that the client enroll in a Part D plan that best covers his/her medications; if the client does not select a plan, he/she will automatically be enrolled in a plan.

## THE ESSENTIAL PLAN

The **Essential Plan** is for people under age 65 with monthly incomes between 138-200% FPL. Those in the Essential Plan can select a Basic Health Program in which to enroll, and will pay either \$0 or \$20 in monthly premiums.

Essential Plan 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 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 may be eligible for a Federal subsidy in the form of a tax credit to help pay for the cost of a plan.

Plans are divided into **four "metal" tiers** – bronze, silver, gold, and platinum. The metal tiers have different cost-sharing (deductibles, co-pays) requirements.

### When can I enroll in a Qualified Health Plan?

**Open enrollment** for the Marketplace takes place annually, usually from November 1 through January 31. After January 31, you will need to wait for the next annual open enrollment period to enroll. There are certain exceptions that allow you to enroll mid-year, including losing current health insurance coverage.

**People with a QHP (Marketplace plan) who become eligible for Medicare** are generally advised to enroll in Medicare when first eligible and drop their QHP by notifying their plan at least 14 days before they want their coverage to end (timed to the start of their Medicare benefits). This is because:

- One cannot continue to get any premium subsidy or cost sharing reduction (to help pay for the QHP premium) after becoming Medicare eligible.
- Having a QHP does not extend their time to enroll in Medicare. Late enrollment could mean a gap in coverage and a late enrollment penalty.
- Beneficiaries are responsible for enrolling in Medicare A, B and D during their Initial Enrollment Period and for dropping QHP coverage.

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

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

## VETERANS' BENEFITS AND TRICARE FOR LIFE

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

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

Effective 2015, VA eliminated the use of net worth as a determining factor for both health care programs and copayment responsibilities. VA now only considers a Veteran's gross household income and deductible expenses from the previous year. To learn more about VA national income thresholds and to calculate your specific geographic-based means test (GMT), visit

<https://www.va.gov/healthbenefits/apps/explorer/AnnualIncomeLimits/Health>

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

### Types of Copayments:

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

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

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

### VA Dental Insurance Program (VADIP)

VA currently provides comprehensive dental benefits to certain eligible veterans. However, there are many veterans who have not been able to access VA dental services due to lack of eligibility. The VA has partnered with two dental insurers, whereby veterans enrolled in the VA health care program and CHAMPVA program beneficiaries can purchase



dental insurance. The dental plans have monthly premiums and copayments. For more information, go to [www.va.gov/healthbenefits/vadip/](http://www.va.gov/healthbenefits/vadip/) or call Delta Dental at 1-855-370-3303 or MetLife at 1-888-310-1681.

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

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

### **How Does VA Drug Coverage Interact with Medicare Part D?**

VA coverage for prescription drugs is considered creditable, meaning it is as good as, or better than, Medicare Part D. It is possible to have both a Part D plan as well as VA drug coverage. If one chooses to forego Part D and then later wishes to enroll in Part D, there will be no penalty for late enrollment. However, one will need to wait until the annual open enrollment period (October 15 – December 7) to enroll in a plan, with coverage starting on January 1, unless the individual qualifies for a special enrollment period.

**TRICARE Health Benefits** provides coverage to active duty service members and their families, families of service members who died while on active duty, former spouses, and retirees and their families, whether or not the veteran is disabled, and National Guards/Reservist members. Military retirees (and their spouses) having served at least 20 years who are 65 years or older and are currently enrolled in Medicare Parts A and B are eligible for TRICARE for Life (TFL). TFL is a premium-free managed health care plan that acts as a supplement to Medicare and includes the TRICARE Express Script Pharmacy program. TRICARE Express Scripts does not cover beneficiaries with a primary commercial pharmacy insurance or Medicare Part D coverage. TFL can be used at the VA but since the VA cannot bill Medicare, the patient is responsible for paying Medicare's portion of the bill. For more information on TRICARE for Life call 1-866-773-0404 or visit <https://tricare.mil/>. An additional benefit of TRICARE is their dental benefit. TRICARE dental benefits consist of: TRICARE Active Duty Dental Program (ADDP) for Active Duty Service Members who are referred by a military dental clinic (MDC) or who lives more than 50 miles from a MDC, the TRICARE Dental Program (TDP) for ADSM's families, National Guard/Reservist and their family members and the TRICARE Retiree Dental Program (TRDP) is for retired SM's and families.

**Civilian Health and Medical Program (CHAMPVA)** is a health insurance program for dependents of 100% permanently and totally disabled veterans with a service-connected disability. CHAMPVA has an annual deductible of \$50 per person or \$100 per family per calendar year. In addition, there is a 25% co-insurance. CHAMPVA does not maintain a provider listing. Most Medicare and TRICARE providers will also accept CHAMPVA (but be sure to ask the provider). If eligible for TRICARE, one cannot be enrolled in CHAMPVA. For more information on CHAMPVA, you can call the VA at 1-800-733-8387 or visit [www.va.gov](http://www.va.gov)

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



## ADVANCE DIRECTIVES

### Your Right to Make Health Care Decisions under the Law

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

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

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

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

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

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

# MEDICARE 2021

## Part A: Hospital Insurance

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

## Part B: Medical Insurance

Monthly Premium	Most Medicare beneficiaries pay the standard premium of \$148.50, except for: <ul style="list-style-type: none"> <li>• Those whose Social Security Cost of Living Adjustment (COLA) didn't increase enough to raise their Part B premiums to the \$148.50 level.</li> <li>• Higher income (over \$88,000 single/176,000 married) beneficiaries will pay higher amounts.</li> </ul>
Annual Deductible	\$203
Co-Insurance	20% for most services

Some people 65 or older do not meet the SSA requirements for **premium-free Hospital Insurance (Part A)**. If you are in this category, you can get Part A by paying a monthly premium. This is called "premium hospital insurance." In 2021, if you have less than 30 quarters of Social Security coverage, your Part A premium is \$471 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium is \$259 per month.

## Medicare Savings Program 2020

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

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

# MEDICAID 2021

## Community Medicaid

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

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

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

### Nursing Home-Based Medicaid (Chronic 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:** individual \$15,900 (excluding: primary residence, automobile and personal possessions if married). The community spouse can retain the following:

**Resources:** \$74,820 minimum; \$130,380 maximum **Income:** \$3,259.50 monthly

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

For more information on Medicaid talk to your HIICAP counselor, Chemung County Department of Aging and Long Term Care, or the NYS Department of Health.

Access our document **Using Medicaid to pay for a Nursing Home Stay:**

<https://cms5.revize.com/revize/chemungcounty/USING%20MEDICAID%20TO%20PAY%20FOR%20A%20NURSING%20HOME%20STAY.pdf>

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

<b>2019 Modified Adjusted Gross Income (MAGI)</b>	<b>Part B Monthly Premium</b>	<b>Part D (Prescription Drug) Monthly Premium</b>
Individuals with a MAGI of \$88,000 or <b>less</b> / Married couples with a MAGI of \$176,000 or <b>less</b>	2021 Standard Premium = \$148.50	Your Plan Premium
Individuals with a MAGI \$88,000-\$111,000/ Married couples with a MAGI \$176,000-\$222,000	\$207.90	Your Plan Premium + \$12.30
Individuals with a MAGI \$111,000-\$138,000/ Married couples with a MAGI \$222,000-\$276,000	\$297.00	Your Plan Premium + \$31.80
Individuals with a MAGI \$138,000-\$165,000/ Married couples with a MAGI \$276,000-\$330,000	\$386.10	Your Plan Premium + \$51.20
Individuals with a MAGI \$165,000-\$500,000/ Married couples with a MAGI \$330,000-\$750,00	\$475.20	Your Plan Premium + \$70.70
Individuals with a MAGI <b>greater than \$500,000</b> / Married couples with a MAGI <b>greater than \$750,000</b>	\$504.90	Your Plan Premium \$77.10
Married filing separately with a MAGI less than \$88,000	\$148.50	Your plan premium
Married filing separately with a MAGI \$88,000-\$412,000	\$475.20	Your Plan Premium + \$70.70
Married filing separately with a MAGI \$412,000 and greater	\$504.90	Your Plan Premium \$77.10

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

## Helpful Health Insurance Definitions

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



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607-737-5520

Fax: 607-737-5521

Office Hours Monday-Friday

8:30am-4:30pm

425 Pennsylvania Avenue

PO Box 588

Elmira NY 14902

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