A Complete Guide to Health Insurance Coverage for Older New Yorkers

2019

紐約市老年人健康保險完全指導手冊

2019
This guide has been developed by the New York City Department for the Aging’s Health Insurance Information, Counseling and Assistance Program (HIICAP) to help older New Yorkers better understand the health care coverage options currently available in New York City. The topics include Medicare Parts A and B, “Medigap” insurance, Medicare Advantage health plans, Medicare Part D, Medicare Savings Programs, and Medicaid. The information detailed here is current at the time of printing. Use it in good health!

HIICAP is New York's source for free, current and impartial information about health care coverage for older people. The HIICAP Helpline can assist you in getting your questions answered. Please call 311 and ask for HIICAP to speak with one of our trained counselors.

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

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

Dial 311 for information regarding this and other City services.

www.nyc.gov/aging
www.aging.ny.gov/healthbenefits
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Coverage Choices Chart</td>
<td>3</td>
</tr>
<tr>
<td>Medicare</td>
<td>4</td>
</tr>
<tr>
<td>Part A</td>
<td>7</td>
</tr>
<tr>
<td>Part B</td>
<td>9</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>13</td>
</tr>
<tr>
<td>Medicare as Secondary Payer (for people with other health insurance, including employer-based coverage)</td>
<td>15</td>
</tr>
<tr>
<td>Medicare Supplement Insurance (Medigap)</td>
<td>18</td>
</tr>
<tr>
<td>Medicare Advantage Plans (HMO, PPO, HMO-POS, SNP)</td>
<td>25</td>
</tr>
<tr>
<td>Medicare Part D-Prescription Drug Coverage</td>
<td>30</td>
</tr>
<tr>
<td>Extra Help Paying for Part D</td>
<td>34</td>
</tr>
<tr>
<td>Elderly Pharmaceutical Insurance Coverage (EPIC)</td>
<td>35</td>
</tr>
<tr>
<td>BigAppleRx Prescription Drug Discount Card</td>
<td>38</td>
</tr>
<tr>
<td>Medicare Savings Programs</td>
<td>39</td>
</tr>
<tr>
<td>Medicare Fraud and Abuse</td>
<td>41</td>
</tr>
<tr>
<td>Medicaid for 65+, Blind or Disabled</td>
<td>43</td>
</tr>
<tr>
<td>Mandatory Medicaid Managed Long Term Care</td>
<td>46</td>
</tr>
<tr>
<td>NY State of Health/Health Insurance Exchange</td>
<td>50</td>
</tr>
<tr>
<td>Medicaid for under 65, not blind, not disabled</td>
<td>51</td>
</tr>
<tr>
<td>Essential Plan</td>
<td>52</td>
</tr>
<tr>
<td>Qualified Health Plan</td>
<td>53</td>
</tr>
<tr>
<td>Veteran’s Benefits and TRICARE for Life</td>
<td>55</td>
</tr>
<tr>
<td>Other Health Coverage Options for New Yorkers</td>
<td>58</td>
</tr>
<tr>
<td>Patient Rights and Appeals</td>
<td>60</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>61</td>
</tr>
<tr>
<td>Long Term Care Planning</td>
<td>62</td>
</tr>
<tr>
<td>Eligibility Charts</td>
<td>65</td>
</tr>
<tr>
<td>Medicaid Offices</td>
<td>67</td>
</tr>
<tr>
<td>Income-Related Monthly Adjustment Amount (IRMMA)</td>
<td>68</td>
</tr>
<tr>
<td>Health Insurance Definitions</td>
<td>69</td>
</tr>
<tr>
<td>Resources</td>
<td>70</td>
</tr>
</tbody>
</table>

CALL 311 AND ASK FOR HIICAP
**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.

决定您如何想要得到保險

聯邦醫療保險 (MEDICARE) 保準選擇

享受聯邦醫療保險的每個人在其如何獲得保險方面所具有的選擇。

有兩種方式得到您的保險 - 原始聯邦醫療保險或聯邦醫療保險優勢計劃。

下文是決策樹，幫助指導決策。

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

**ORIGINAL MEDICARE**
(red, white and blue card)

- **Part A**
  Hospital Insurance

- **Part B**
  Medical Insurance

**MEDICARE ADVANTAGE (MA)**
(HMO, PPO, HMO-POS)

- **Part D**
  Prescription Drug Plan (PDP)
  Offered by private companies

决定您是否需要增加藥物承保範圍

原始聯邦醫療保險
(紅卡、白卡和藍卡)

或

聯邦醫療保險 (MEDICARE) 優勢
(HMO、PPO、HMO-POS)

如果您需要藥物保險，聯邦醫療保險優勢計劃結合醫療保險 A 部分、B 部分福利以及 D 部分福利。其提供方為私營公司。

聯邦醫療保險優勢計劃加成者不能購買 Medigap 保單或單獨的 D 部分計劃。

**Decide if you need to add drug coverage**

Medicare Advantage plans combine Medicare Part A, Part B benefits, as well as Part D benefits, if you want drug coverage. They are offered by private companies.

Medicare Advantage enrollees cannot purchase a Medigap policy or a separate Part D plan.

決定您是否需要增加藥物承保範圍

**Decide if you need to add supplemental coverage**

Supplemental coverage pays for some or all of the out-of-pocket Medicare Part A and Part B costs. Examples include: retiree health coverage, Medigap, and Medicaid.

決定您是否需要增加補充保險

補充保險支付聯邦醫療保險 A 部分和 B 部分的一些或全部自付費用。範例包含：退休人員健康保險、Medigap 及醫療補助。
MEDICARE

Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people and people with kidney failure. It has four components:

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

Who is Eligible for Medicare?

- Age: You are eligible for Medicare if you are 65 years old or older and either
  - A U.S. citizen or
  - Legal permanent resident for at least five consecutive years (if not eligible for Social Security).
- People under age 65 can qualify for Medicare:
  - After receiving Social Security Disability Insurance (SSDI) for 24 months. Individuals with Amyotrophic Lateral Sclerosis (ALS) qualify the first month they receive SSDI.
  - Individuals with end stage renal disease (ESRD) can qualify for Medicare, regardless of age. A worker, as well as a worker’s spouse (including same-sex spouse) or children may be eligible for Medicare, based on the worker’s work record, if she or he receives continuing dialysis for permanent kidney failure or had a kidney transplant, even if no one else in the family is getting Medicare.

If you or your spouse (including same-sex spouse) are insured through Social Security (by having earned 40 quarters of coverage), you are eligible for premium-free Part A at age 65. Without 40 quarters of coverage, one may still get Medicare by paying a premium for Part A at age 65.

One does not need 40 quarters of coverage to qualify for Part B.

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

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險 (MEDICARE)

聯邦醫療保險是針對 65 歲或以上老人，某些未達此年齡的殘障人士及腎臟衰竭患者而設的全國性醫療保險計劃。含有四部分：

- 住院保險（A 部分）。
- 醫療保險（B 部分）。
- 聯邦醫療保険優勢計畫（C 部分 - HMO，PPO，特殊需求計畫）。聯邦醫療保険優勢計畫提供住院和醫療保険。參加聯邦醫療保険優勢計畫者將經由該項私营計畫取得保険，而非透過「聯邦醫療保険原始計畫」。
- 處方藥保険（D 部分）。參加聯邦醫療保険優勢計畫者若需要藥品保険，必須透過該計畫取得此項保険。參加「聯邦醫療保険原始計畫」者若需要藥品保険，則應參加單行的 D 部分計畫。

誰有資格申請參加聯邦醫療保険？

- 年齡：如果年滿 65 歲以上，即適用於聯邦醫療保険 (Medicare)，並且為
  - 美國公民或
  - 連續居住 5 年的合法永久居民（如未符合社會安全資格）。
- 65 歲以下的人士可符合聯邦醫療保険資格
  - 在接受 24 個月的社會安全殘疾保険（SSDI）之後，肌萎縮性脊髄側索硬化症
    （Amyotrophic Lateral Sclerosis, ALS）之患者在接到 SSDI 第一個月即符合資格。
  - 末期腎臟疾病（ESRD）患者皆有資格參加聯邦醫療保険，不受年齡限制。勞工，以及
    勞工的配偶（包括同性配偶）或其未成年子女有資格參加聯邦醫療保険，在勞工的工作記
    錄而定，若其因永久性腎臟衰竭而必須接受洗腎或腎移植，即使在家中無其他
    成員亦得參加。

若您或配偶（包括同性配偶）擁有社會安全保險（已積滿 40 個工作季節）者，尚在 65 歲時有
資格免付保険取得 A 部分保険計畫。若尚未積滿 40 個工作季節，個人仍可以在 65 歲時行
使 A 部分保険而取得聯邦醫療保険。

您不需要積滿 40 個工作季節，即可符合 B 部分的資格。

如對自己參加聯邦醫療保険的資格有疑問，或是有意申請聯邦醫療保険，請致電社會安全局
1-800-772-1213（1-800-325-0778 聽障專線）。欲進一步瞭解如何申請聯邦醫療保険，請至
www.socialsecurity.gov.
How Do I Enroll in Medicare?
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.
- If you receive Social Security Disability benefits, you will automatically get a Medicare card in the mail after you have received Social Security Disability benefits for 24 consecutive months. If you wish to decline Medicare benefits, follow the instructions mailed with the Medicare card.

If you are not receiving Social Security benefits as you approach age 65, and you want your Medicare benefits at age 65, it is important to understand the different enrollment periods. You must apply for Medicare benefits by reaching out to the Social Security Administration. You can call 1-800-772-1213, visit a local Social Security office, or you may be able to enroll online at www.socialsecurity.gov.

Applying for Medicare Part A: Individuals eligible for premium-free Part A at age 65 can enroll in Medicare Part A at any time, and coverage can be retroactive up to six months. Those who need to pay a premium for Part A (don’t have 40 quarters of coverage through Social Security) can only enroll during their Initial Enrollment Period, and thereafter only from January 1-March 31, with coverage effective July 1. These individuals may incur a Late Enrollment Penalty.

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

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

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

如何加入聯邦醫療保險？
以下對象在符合資格時即被自動納入聯邦醫療保險：

- 若您在年滿 65 歲時已開始領取社會安全福利金或鐵道退休福利金，則無須自己申請聯邦醫療保險。您自動加入 A 部分和 B 部分，而且您的聯邦醫療保險卡將在您的 65 歲生日之前 3 個月寄送給您。
- 若您領取社會安全殘障福利金，在連續 24 個月領取社會安全殘障福利金之後，聯邦醫療保險卡將自動寄送給您。若您想拒絕聯邦醫療保險福利，請遵循聯邦醫療保險卡所郵寄的說明。

如果您在達到 65 歲時未領取社會安全福利，且您希望在 65 歲時享有聯邦醫療保險福利，那麼瞭解不同的登記期則很重要。您必須聯繫社會安全局申請聯邦醫療保險福利。您可以致電 1-800-772-1213 或造訪當地社會安全局辦事處，也可以造訪 www.socialsecurity.gov 線上登記加入。

申請聯邦醫療保險 A 部分：65 歲時符合 A 部分免保費資格的人士可隨時加入聯邦醫療保險 A 部分；而且保障可往回追溯最多 6 個月。至於必須自行支付 A 部分保費者（尚未取得 40 個社會安全工作季節），只能在其初始登記期內，而此後只能從 1 月 1 日至 3 月 31 日登記加入，保障自 7 月 1 日起生效，這些人士可能需繳交延遲登記罰款。

申請聯邦醫療保險 B 部分：若您年滿 65 歲時尚未領取社會安全福利金，則有 7 個月的首次參加期 (IEP) 可登記加入聯邦醫療保險。您可以在年滿 65 歲之前 3 個月，以及年滿 65 歲的當月及之後的 3 個月內，聯絡社會安全局 (SSA) 登記加入。

- 若您在生日之前 3 個月登記加入，您的聯邦醫療保險的保障將自您生日所在月份的第一天生效。
- 若您在生日當月登記加入，您的保障將自下一個月的第一天生效。
- 若您在生日之後的 1 個月登記加入，您的保障將自 2 個月後生效。
- 若您在生日之後的 2 或 3 個月登記加入，您的保障將自 3 個月後生效。

註：對於出生於當年第一的人，聯邦醫療保險資格就從上個月第一天開始。

CALL 311 AND ASK FOR HIICAP

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

Actively Employed and Medicare Eligible: If you or your spouse are actively employed and have health insurance through that employer or union, you may not need to enroll in Medicare Part B when you first become eligible; contact the employer or union as to whether they require enrollment in Part B. You may wish to enroll in Part A regardless because there is no premium for this coverage, though this is prohibited if you are contributing to a Health Savings Account (HSA). Refer to the section on Medicare as Secondary Payer (see page 15) for more information.

Medicare Card Replacement: The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires that Medicare no longer use Social Security numbers on their cards in order to prevent identity theft. Medicare completed the mailing of new Medicare cards by December 2018 to New York residents. The new cards have a randomly assigned identifier, not related to any personal information. The new Medicare beneficiary identifier (MBI) has 11 characters, consisting of both uppercase letters and numbers. Spouses will each have their own unique MBI, regardless of whether one spouse has Medicare based on the other spouse’s work record. Call 1-800-MEDICARE if you did not receive your new Medicare card.

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

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, or they can receive their Medicare benefits through a Medicare Advantage plan, in which a private company provides them with all Medicare benefits. Medicare Advantage enrollees cannot submit bills to Medicare. This section below explains how Original Medicare functions, as well as costs in the original Medicare program.

若您在這 7 個月期間未登記加入，而且並未透過（您或您配偶的）現任雇主獲得健康保險，將必須等到一般參加期才能登記加入，一般參加期為每年 1 月 1 日至 3 月 31 日。不過，B 部分保險將至 7 月才開始生效。若您未在首次參加期間登記加入，亦未經由您本人或配偶的現有雇主投保其他保險，您可能會因延遲登記而須繳付更高保費作為罰款。未登記加入 B 部分，每整 12 個月的延遲登記罰款為 10%。註：COBRA 並不適用於這項雇主投保，因此 COBRA 不會讓您有資格獲得特殊登記期。

受雇就業與聯邦醫療保費資格：若您或配偶現為受僱就業並由該雇主或工會處取得醫療保費，當您初次符合資格時，可能無須登記加入聯邦醫療保費 B 部分；請聯絡該雇主或工會查詢其是否要求登記加入 B 部分。但您仍可能有意加 A 部分，因為此項保費無需保費，但若您仍在向健康儲蓄帳戶 (HSA) 撥款將被禁止加入 A 部分。請參考「聯邦醫療保費為副保費」（第 15 頁）的部分以瞭解詳情。

更換聯邦醫療保險卡：2015 年頒布的「醫療服務可及性與兒童健康保險項目再授權法」要求聯邦醫療保險卡不再使用卡上的社會安全號碼為防止身份盜用。聯邦醫療保費在 2018 年 12 月之前完成了寄送新的聯邦醫療保險保險卡給紐約居民。這些新的卡片有隨機給予的識別碼，與任何個人資料無腳，新的醫療保險保險人識別碼 (MBI) 由 11 位字元組成，包含大寫字母和數字。配偶雙方均會獲得各自唯一的 MBI，無論其中一方的聯邦醫療保費是否有賴於另一方的工作記錄，若您未收到新的聯邦醫療保險保險卡，請致電 1-800-MEDICARE。

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

要領：為找尋聯邦醫療保險計畫的醫療業者，請造訪 www.medicare.gov 或致電 1-800-MEDICARE。

聯邦醫療保險計畫選擇

聯邦醫療保險受益人能夠選擇如何接收他們的聯邦醫療保險福利。他們可以享有聯邦醫療保險原創計畫（Original Medicare），使用紅、白、藍的聯邦醫療保險卡來支付所有 A 部分與 B 部分涵蓋的服務，或者通由聯邦醫療保險優勢計畫（Medicare Advantage）計畫享受福利。在此情況下，會由私人公司為他們提供所有聯邦醫療保險福利。聯邦醫療保險優勢計畫的投保者不能向聯邦醫療保費提交帳單。以下區域說明聯邦醫療保險原創計畫如何運作，以及此類計畫的費用。
Medicare Part A Benefits

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

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

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

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

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

Most people are eligible for premium-free Part A because they or their spouse have at least 40 quarters of coverage with Social Security. Those who do not have 40 quarters of coverage with Social Security can pay a monthly premium for Part A coverage. In 2019, if you have less than 30 quarters of Social Security coverage, your Part A premium will be $437 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium will be $240 per month. For low-income beneficiaries who qualify for the QMB Medicare Savings Program (see page 39), QMB may also be able to pay the Part A premium for those who do not qualify for premium-free Part A.

Part A Inpatient Hospitalization Cost Sharing in 2019:
- Deductible: $1,364 per benefit period
- Days 61-90 of an inpatient stay: $341 per day
- Lifetime Reserve Days: $682 per day

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險 A 部分的保險賠付

聯邦醫療保險 A 部分承保住院治療、專業護理設施、居家護理和安寧療護。

聯邦醫療保險優勢計劃的參加者是透過該計劃取得 A 部分的保險賠付獲得保障，而非根據單獨

住院治療：於權益期間在聯邦醫療保險認可的綜合醫院或精神病院接受必要治療，聯邦醫療保

險將賠付最多達 90 天。權益期從您辦理住院開始，算至您連續 60 天在醫院或專業護理設施

接受住院治療為止。聯邦醫療保險受益人在每一段權益期的第 90 天之後，即有 60 天終身儲備

期 (lifetime reserve days).

對於在精神病院所接受的住院精神病治療，聯邦醫療保險將賠付的終身儲備期最高期限為 190

天。當終身儲備期 190 天用盡之後，聯邦醫療保險將僅賠付受益人在綜合醫院接受住院精神病

治療。

住院時，聯邦醫療保險 A 部分會幫助支付雙人病房、膳食、普通護理服務、康復服務、藥品、

醫療用品、醫療檢驗和 X 光。您還會得到下列承保項目：使用手術室和恢復室、心理健康服務、

加護病房和心臟重症加護病房，以及所有其他的必要醫療服務和醫療用品。

只要本人或配偶累積至少 40 個社會安全工作季節，多數人都有資格獲得免保費的 A 部分計畫。

如果尚未取得 40 個社會安全工作季節，可支付月保費以取得 A 部分保險。在 2019 年，若您的

社會安全保險少於 30 個工作季節，A 部分保費將是每月 $437。若您的社會安全保險累積了 30

至 39 個工作季節，A 部分保費將是每月 $240。至於有資格申請 QMB 聯邦醫療保險免保費計畫

（請見第 39 頁）者，QMB 或許也能為無資格獲得免保費 A 部分者支付 A 部分的保費。

2019 年 A 部分承保住院治療病患之分擔費用：
- 自付額：每一段權益期為 $1,364
- 住院治療第 61 天至 90 天：每天 $341
- 終身儲備期：每天 $682

請致電 311 洽詢 HIICAP
**Skilled Nursing Facility Care:** If after being discharged after a three-day minimum stay as an inpatient in a hospital (not counting the day of discharge), you need to go to a skilled nursing facility (SNF), Medicare will help pay for your care for up to 100 days in a benefit period. (Days under “observation” status in a hospital are covered under Medicare Part B, and are not counted towards the three-day qualifying minimum stay for SNF coverage.) Medicare Part A pays the full cost of covered services for the first 20 days. All covered services for the next 80 days are paid for by Medicare except for a daily co-payment amount of $170.50 in 2019. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day. **Note:** A stay in a skilled nursing facility is not long term care.

**Observation Status**

Hospitals are required to provide Medicare beneficiaries with a Medicare Outpatient Observation Notice (MOON) if they are being held under “observation” for more than 24 hours. Observation is covered by Part B, not Part A, and does not count towards the minimum 3-day inpatient stay that allows for Medicare Part A coverage in a SNF.

**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. Depending on the circumstances, home care can be covered by either Part A or Part B. Home care is covered at 100%. A prior stay in the hospital is not required to qualify for home health care. The services may be provided on a part-time or intermittent basis, not full-time. Coverage is provided for skilled care, including skilled nursing care, physical, occupational, and speech therapy. If you are receiving skilled care, you may also qualify for other services, such as a home health aide and medical social worker.

Those with both Medicare and Medicaid who receive Medicaid-covered home care services must enroll in a managed long term care (MLTC) plan. See page 46 for more information on MLTC.

**Hospice Care:** Medicare beneficiaries who are terminally ill can elect to receive hospice care rather than regular Medicare benefits. Hospice care emphasizes providing comfort and relief from pain. The care can be at home or as an inpatient, and includes many services usually not covered by Medicare, such as homemaker services, counseling, and certain prescription drugs.

**CALL 311 AND ASK FOR HIICAP**

**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. Depending on the circumstances, home care can be covered by either Part A or Part B. Home care is covered at 100%. A prior stay in the hospital is not required to qualify for home health care. The services may be provided on a part-time or intermittent basis, not full-time. Coverage is provided for skilled care, including skilled nursing care, physical, occupational, and speech therapy. If you are receiving skilled care, you may also qualify for other services, such as a home health aide and medical social worker.

Those with both Medicare and Medicaid who receive Medicaid-covered home care services must enroll in a managed long term care (MLTC) plan. See page 46 for more information on MLTC.

**Hospice Care:** Medicare beneficiaries who are terminally ill can elect to receive hospice care rather than regular Medicare benefits. Hospice care emphasizes providing comfort and relief from pain. The care can be at home or as an inpatient, and includes many services usually not covered by Medicare, such as homemaker services, counseling, and certain prescription drugs.

**Observation Status**

Hospitals are required to provide Medicare beneficiaries with a Medicare Outpatient Observation Notice (MOON) if they are being held under “observation” for more than 24 hours. Observation is covered by Part B, not Part A, and does not count towards the minimum 3-day inpatient stay that allows for Medicare Part A coverage in a SNF.

**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. Depending on the circumstances, home care can be covered by either Part A or Part B. Home care is covered at 100%. A prior stay in the hospital is not required to qualify for home health care. The services may be provided on a part-time or intermittent basis, not full-time. Coverage is provided for skilled care, including skilled nursing care, physical, occupational, and speech therapy. If you are receiving skilled care, you may also qualify for other services, such as a home health aide and medical social worker.

Those with both Medicare and Medicaid who receive Medicaid-covered home care services must enroll in a managed long term care (MLTC) plan. See page 46 for more information on MLTC.

**Hospice Care:** Medicare beneficiaries who are terminally ill can elect to receive hospice care rather than regular Medicare benefits. Hospice care emphasizes providing comfort and relief from pain. The care can be at home or as an inpatient, and includes many services usually not covered by Medicare, such as homemaker services, counseling, and certain prescription drugs.

**CALL 311 AND ASK FOR HIICAP**

**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. Depending on the circumstances, home care can be covered by either Part A or Part B. Home care is covered at 100%. A prior stay in the hospital is not required to qualify for home health care. The services may be provided on a part-time or intermittent basis, not full-time. Coverage is provided for skilled care, including skilled nursing care, physical, occupational, and speech therapy. If you are receiving skilled care, you may also qualify for other services, such as a home health aide and medical social worker.

Those with both Medicare and Medicaid who receive Medicaid-covered home care services must enroll in a managed long term care (MLTC) plan. See page 46 for more information on MLTC.

**Hospice Care:** Medicare beneficiaries who are terminally ill can elect to receive hospice care rather than regular Medicare benefits. Hospice care emphasizes providing comfort and relief from pain. The care can be at home or as an inpatient, and includes many services usually not covered by Medicare, such as homemaker services, counseling, and certain prescription drugs.

**CALL 311 AND ASK FOR HIICAP**
Medicare Part B Benefits

Part B of Medicare pays for a wide range of medical services and supplies, but most important is that it helps pay for doctor bills. The medically necessary services of a doctor are covered whether the care is at home, in the doctor’s office, in a clinic, in a nursing home, or in a hospital. Part B also helps pay for:

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

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

What Do You Pay Under Part B?

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

In 2019 the standard monthly premium is $135.50. About 3.5% of Medicare beneficiaries will be paying less than this amount. This has to do with Social Security’s Cost of Living Adjustment (COLA) increases for prior years; the COLA increases did not keep pace with the Part B Premium increases. Medicare beneficiaries were “held harmless” from a premium increase that would have resulted in a reduction in their net Social Security check. The 2019 COLA will be 2.8%. While beneficiaries’ gross Social Security benefits will increase 2.8%, the increase will go towards raising their Part B premium to the $135.50 amount.

Higher income individuals (over $85,000 for individuals; $170,000 for married couples) will be responsible for higher premiums, known as the Income Related Medicare Adjustment Amount (IRMAA). Social Security determines whether each person is subject to IRMAA by looking at tax filings for 2-years prior; IRMAA is re-evaluated each year. For example, in 2019, SSA looks at your 2017 tax filings. You can request that SSA reconsider your IRMAA amount due to a life-changing event by submitting form SSA-44 (www.ssa.gov/forms/ssa-44.pdf). See page 68 for more information for the current IRMAA amounts.

You are responsible for paying the annual Part B deductible, $185 in 2019. After meeting the deductible, Medicare pays for 80% of Medicare-approved charges. You are responsible for paying the other 20%, referred to as the Medicare coinsurance.

CALL 311 AND ASK FOR HIICAP
Prior to January 2018 there was a dollar limit on "physical, speech and occupational therapy" services covered by Medicare within a calendar year. Although there is no longer a cap, if you reach a certain dollar threshold the therapist needs to confirm that your therapy services are medically reasonable and necessary.

Can You Get Help with Cost-Sharing Under Original Medicare?
There are several ways to help cover the cost-sharing under Original Medicare. Examples include:

- Medicare Supplement Insurance (Medigap) helps Medicare beneficiaries pay their share of the costs not covered by Medicare. These policies fill in the "gaps" of Medicare’s reimbursement, but only for the approved services under Medicare coverage. See page 18 for more information on Medigap policies.
- Retiree/Union Benefits may work with Original Medicare. You’d need to speak to the benefits administrator to understand the policy.
- Medicaid works to cover Medicare cost-sharing, as long as you meet Medicaid eligibility requirements. For more information, see page 43.

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 they can charge to see a Medicare beneficiary. Non-participating providers can either "Participate", "Non-Participating" or they can "Opt Out" of the Medicare program. Below are descriptions of each of these scenarios.

- If a provider is a "Participating" provider, they will always accept the Medicare allowed amount as payment in full (Medicare pays 80% and the beneficiary pays 20%, after you meet the Part B deductible). If you want to find out whether a provider is participating, you can ask, "Is the doctor a participating provider in the Medicare program?" It is best to ask this question when making an appointment, and also to confirm this information at the time of the appointment.
- "Non-Participating" providers still have a relationship with the Medicare program; however, this category differs from "Participating" providers in terms of how much they can charge to see a Medicare beneficiary. Non-participating providers can either "accept assignment" or "not accept assignment" on each claim. If you learn that a provider is Non-Participating, ask, "Will the doctor accept assignment for my claim?"
  - If a provider accepts assignment, he or she will accept the amount Medicare approves for a particular service and will not charge you more than the 20% co-insurance (for most services), after you have met the Part B deductible.
  - If a provider does not accept assignment, the charges are subject to a "Limiting Charge," which is an additional charge over the Medicare-approved amount. The Limiting Charge that applies for office visits and home visits is 15%. For most other services provided by physicians in New York State, the Limiting Charge is 5%.
  - NOTE: It is common for providers who do not accept assignment to request payment in full at the time of the services. The provider will submit the claim to Medicare and Medicare will reimburse the beneficiary for the 80%.

CALL 311 AND ASK FOR HIICAP

2018 年 1 月之前，在一個日歷年內由聯邦醫療保費支付的物理、語言及職能治療服務為美元金額上限。雖然之後不再有上限，如果您達到特定美元門檻，治療師需要確認您的治療服務皆為合理且必要的醫療措施。

我是否能獲得聯邦醫療保費原始計畫費用分攤的支付協助？
有數種方法有助於獲得聯邦醫療保費原始計畫的費用分攤協助，範例包含：
- 聯邦醫療保費補充保險（Medigap）協助聯邦醫療保費受益人支付聯邦醫療保費不附帶的分攤費用部分，這些補充性保險能補償聯邦醫療保費付款的「剩餘部分」，但限僅於依聯邦醫療保費承保項目所核准的服務，關於醫療補充保險的規定請參見第 18 頁。
- 退休/工會福利可與聯邦醫療保費原始計畫搭配使用。您需要諮詢福利管理員，以瞭解保單內容。
- 只要您符合醫療補助（Medicaid）資格要求，醫療補助可承保聯邦醫療保費費用分攤，請參見第 43 頁瞭解詳情。

醫療業者可就服務項目收取多少費用？
醫生與醫療業者可選擇與聯邦醫療保費計畫之間存在不同的關係，醫療業者的類別會影響您對其服務所需支付的款項，醫療業者可以「參與」、「不參與」或「退出」聯邦醫療保費計畫，以下是各個情境的描述。

- 若醫療業者「參與」，他們將始終接受聯邦醫療保費所容許的金額作為收取的金額（在您滿足 B 部分自付額條件之後，聯邦醫療保費支付 80%，受益人支付 20%）。若您想知道醫療業者是否「參與」，您可以詢問：「醫生是否參與聯邦醫療保費計畫？」最好在作預約時詢問，也可以在就診時確認此資訊。
- 「不參與」的醫療業者仍可與聯邦醫療保費計畫存在關聯；這類醫療業者與「參與」醫療業者的不同之處在於他們向聯邦醫療保費受益人的收費。不參與的醫療業者可向其患者解釋「接受費用安排」或「不接受費用安排」。若您想知醫療業者不參與計畫，則可以查詢：「醫生是否對我的理療接受費用安排？」
  - 若醫療業者接受費用安排，他或她將接受聯邦醫療保費就特定服務所核准的費用金額，而且在您滿足 B 部分自付額條件之後，對您的收費不超過 20% 的共付額（就大多數服務而言）。
  - 若醫療業者不接受費用安排，則費用將受到「限制收費」的約束，此為在聯邦醫療保費所容許的金額之外的額外收費，適用於診所和居家護理的限制收費為 15%，對於在紐約州內由醫生提供的大多數其他服務，限制收費為 5%。
  - 註：對於不接受費用安排的醫療業者而言，常見的是要求在服務時金額付款，醫療業者將會向聯邦醫療保費提交索賠，而聯邦醫療保費將會為受益人報銷 80%。

請致電 311 洽詢 HIICAP
Providers can "Opt Out" of the Medicare program. Medicare providers have the right to officially "opt out" of Medicare for a two-year period and enter into a private written contract with any Medicare patient who seeks their treatment. The doctor will set a fee for each specific service and the patient agrees to pay the costs, understanding that Medicare will not pay that doctor or reimburse the patient. A Medicare supplement policy (Medigap) will not pay any of these costs either. The Medicare beneficiary is still covered by Medicare for services by other providers. "Opting Out" is different from providers who do not accept Medicare Assignment, where the set fees and reimbursements are still controlled by Medicare.

Advance Beneficiary Notice of Non-Coverage
If a provider is not sure that Medicare will consider a service "medically necessary," and therefore not approve a claim, the provider must present the beneficiary with an "Advance Beneficiary Notice of Non-coverage (ABN)" form, indicating the service for which Medicare may not pay. The form must specify the service in question; the date of the service; a specific reason why the service may not be paid for by Medicare; and a place for the beneficiary to sign as proof that they understand and accept responsibility to pay for the service. The beneficiary is not responsible to pay unless he or she signed a valid ABN. The ABN does not apply to services never covered by Medicare (i.e. hearing aids), which are always the beneficiary's responsibility. Without a signed ABN, the beneficiary is not responsible for charges in excess of the cap for these services (see following page for a sample ABN). The beneficiary retains appeal rights, even with a signed ABN. A sample ABN is found on the next page.

Medicare Summary Notice
For assigned claims, a Medicare Summary Notice (MSN) will be mailed quarterly to each Medicare beneficiary for whom a Part A and/or Part B claim was submitted by a provider. For unassigned claims, a MSN will be mailed as the claims are processed, along with a check to the beneficiary if the beneficiary has already paid for the service. Beneficiaries will be able to utilize the MSN for reimbursement from a Medigap policy. The MSN also contains information on how you can appeal Medicare claim denials. Beneficiaries can also access their MSNs electronically at www.mymedicare.gov. One can request to receive the MSN in Spanish by calling 1-800-MEDICARE.

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

CALL 311 AND ASK FOR HIICAP
**Advance Beneficiary Notice of Noncoverage (ABN)**

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

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

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay:</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**WHAT YOU NEED TO DO NOW:**

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

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

**G. OPTIONS:**

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

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

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

**H. Additional Information:**

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

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

**I. Signature:**

**J. Date:**
# Medicare Preventive Services

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal Aortic Aneurysm Screening</strong></td>
<td>Medicare covers an abdominal aortic screening ultrasound once if you have a family history of abdominal aortic aneurysms, or are a man age 65-75 and have smoked at least 100 cigarettes in your lifetime.</td>
</tr>
<tr>
<td><strong>Alcohol Misuse Screening and Counseling</strong></td>
<td>Medicare covers an annual screening for alcohol misuse. For those who screen positive, Medicare will also cover up to four brief, face-to-face behavioral counseling interventions annually.</td>
</tr>
<tr>
<td><strong>Behavioral Therapy for Cardiovascular Disease (CVD)</strong></td>
<td>Medicare covers one face-to-face CVD risk reduction visit annually. The visit encourages aspirin use, screening for high blood pressure, and behavioral counseling to promote a healthy diet.</td>
</tr>
<tr>
<td><strong>Bone Mass Measurements</strong></td>
<td>Procedures to identify bone loss, or determine bone density are covered every 24 months. Women at risk for osteoporosis or who are receiving osteoporosis therapy and persons with spine abnormalities qualify for these procedures.</td>
</tr>
<tr>
<td><strong>Cardiovascular Screening</strong></td>
<td>Medicare covers cardiovascular screenings that check cholesterol and other blood fat (lipid) levels once every 5 years.</td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screening</strong></td>
<td>Fecal Occult Blood Test: covered once every 12 months. Flexible Sigmoidoscopy: covered once every 48 months. Colonoscopy: covered once every 24 months if you are at higher risk for colon cancer. If you are not at higher risk it is covered once every 10 years but not within 48 months of a screening flexible sigmoidoscopy. Barium Enema: this can be substituted for a flexible sigmoidoscopy or colonoscopy; you pay 20% of the Medicare-approved amount. Cologuard™ test: covered once every 3 years for people with Medicare who are between 50 and 85 years old; show no signs or symptoms of colorectal disease; and are at average risk of developing colorectal cancer.</td>
</tr>
<tr>
<td><strong>Depression Screening</strong></td>
<td>Medicare covers depression screenings by your primary care doctor once every 12 months.</td>
</tr>
<tr>
<td><strong>Diabetes Services</strong></td>
<td>Diabetes screenings for those at higher risk covered at 100%. Coverage for glucose monitors, lancets, test strips and diabetes self-management training for both insulin and non-insulin dependent of those diagnosed with diabetes. You pay 20% of the Medicare-approved amount after the Part B deductible.</td>
</tr>
<tr>
<td><strong>Glaucoma Screening</strong></td>
<td>People at high risk for glaucoma, including people with diabetes or a family history of glaucoma, are covered once every 12 months. You pay 20% of the Medicare-approved amount after the Part B deductible.</td>
</tr>
<tr>
<td><strong>Hepatitis B Screening</strong></td>
<td>Medicare covers an annual Hep B screening for those at risk who do not get a Hep B shot; Medicare also covers Hep B screening for those who are pregnant.</td>
</tr>
</tbody>
</table>

**Contact:**

CALL 311 AND ASK FOR HIICAP
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis C Screening</td>
<td>Medicare covers one Hepatitis C screening test for people born between 1945-1965, and a yearly repeat screening for certain people at high risk.</td>
</tr>
<tr>
<td>HIV Screening Test</td>
<td>Covered once every 12 months for any beneficiary who requests the test.</td>
</tr>
<tr>
<td>Lung Cancer Screening</td>
<td>Medicare covers lung cancer screening every 12 months for people who are age 55-77 and are either a current smoker or have quit smoking within the last 15 years.</td>
</tr>
<tr>
<td>Mammogram Screening</td>
<td>One baseline mammogram is covered between ages 35 and 39. All women with Medicare, aged 40 and older, are provided with coverage for a screening mammogram every 12 months. A diagnostic mammogram is covered at any time there are symptoms of breast cancer. The diagnostic mammogram is subject to the Part B deductible and 20% co-insurance.</td>
</tr>
<tr>
<td>Medical Nutrition Therapy</td>
<td>Medicare covers 3 hours of one-on-one counseling services the first year, and 2 hours each year after that for beneficiaries with diabetes or kidney disease.</td>
</tr>
<tr>
<td>Obesity Screening and Counseling</td>
<td>If you have a body mass index of 30 or more, Medicare covers a dietary assessment as well as intensive behavioral counseling and behavioral therapy.</td>
</tr>
<tr>
<td>Pap Test and Pelvic Exam</td>
<td>A pap test, pelvic exam and clinical breast exam are covered every 24 months, or once every 12 months for women at higher risk for cervical or vaginal cancer. All women with Medicare are covered.</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>An initial preventive physical exam will be covered during the first twelve months of Medicare Part B enrollment. Also, an annual wellness visit is covered for all people with Medicare Part B, but not within 12 months of the initial exam.</td>
</tr>
<tr>
<td>Prostate Cancer Tests</td>
<td>Digital Rectal Examination: Covered once every 12 months for men aged 50 and older. You pay 20% of the Medicare-approved amount after the Part B deductible. Prostate Specified Antigen (PSA) blood screening test: Covered once every 12 months for men aged 50 and older.</td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STIs) Screening and High-Intensity Behavioral Counseling (HIBC) to prevent STIs</td>
<td>Medicare covers screening for chlamydia, gonorrhea, syphilis and Hepatitis B, as well as high intensity behavioral counseling (HIBC) to prevent STIs. The screening is for up to two individual 20 to 30 minute, face to face counseling sessions annually for those at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting.</td>
</tr>
<tr>
<td>Smoking Cessation Counseling</td>
<td>Counseling to stop smoking. Medicare will cover up to 8 face-to-face visits during a 12-month period for beneficiaries who use tobacco.</td>
</tr>
<tr>
<td>Vaccinations/ Shots</td>
<td>Flu: Covered once per flu season. Pneumonia: Usually only needed once in a lifetime. A different, second shot, is covered 12 months after you get the first shot. Hepatitis B: Covered if at high or intermediate risk.</td>
</tr>
<tr>
<td>HIV 防治</td>
<td>聯邦醫療保險為 1945-1965 年出生的人承保一次 HIV 防治，並為特定的高風險人士承保每年一次的複檢。</td>
</tr>
<tr>
<td>感染病原體篩檢試劑</td>
<td>任何要求篩檢的受益人每 12 個月可進行一次。</td>
</tr>
<tr>
<td>肝癌篩檢</td>
<td>聯邦醫療保險為 55-77 歲的人以及現在懷孕或在過去 15 年內懷孕的人每 12 個月承保一次肝癌篩檢。</td>
</tr>
<tr>
<td>乳房造影檢查</td>
<td>35 歲至 39 歲可進行一次基本乳房造影，擁有聯邦醫療保險的 40 歲以上婦女，每 12 個月可進行一次乳房造影檢查。有乳癌症狀出現時，或由醫生診斷為高風險狀況時，每年可進行一次造影檢查。貝利氏乳房造影的規則適用於此。</td>
</tr>
<tr>
<td>醫療腫瘤治療</td>
<td>對於患有糖尿病或腎臟病的受益人，聯邦醫療保險的赔付包括第一年 3 小時的一對一諮詢輔導服務，其後則是每年 2 小時。</td>
</tr>
<tr>
<td>哨所切開篩檢與 辅導</td>
<td>身體質量指數若達 30 或以上，膳食評估、密集式行為輔導以及行為治療可獲聯邦醫療保險賠償。</td>
</tr>
<tr>
<td>子宮頸抹片檢查和 膀胱鏡檢查</td>
<td>每 24 個月可進行一次子宮頸抹片檢查，膀胱鏡檢查和臨床乳房造影。特別是子宮頸篩查結果指示有宮頸浸潤腺瘤的婦女，每 12 個月做一次檢查。擁有聯邦醫療保險的受益人可獲聯邦醫療保險賠償。</td>
</tr>
<tr>
<td>體檢</td>
<td>加入聯邦醫療保險 B 部分之後的 12 個月內可進行首次預防性體檢。另外，所有加入聯邦醫療保險 B 部分的人士，每年都可以做一次健康檢查。但在體檢後的 12 個月之內不得進行。</td>
</tr>
<tr>
<td>前列腺癌篩檢</td>
<td>前列腺指標：50 歲以上男性可以每 12 個月檢查一次，在扣除 B 部分自付額後支付聯邦醫療保險手續費之 20%。</td>
</tr>
<tr>
<td>前列腺特異抗原 (PSA) 血液檢測</td>
<td>50 歲以上男性每 12 個月可做一次。</td>
</tr>
<tr>
<td>性傳播疾病感染 (STI)篩檢與預防</td>
<td>聯邦醫療保險承保對衣原體感染、淋病、梅毒和 B 型肝炎的篩査，以及預防性傳播疾病感染的高度密集式行為輔導 (HIBC)。對於可能罹患 STI 的高風險群，每年可以進行最多兩次篩檢的 20 至 30 分鐘面對面輔導。前提是此項服務必須由主診醫生轉介，並且是由符合聯邦醫療保險資格的主診醫生在第一線醫療環境進行。</td>
</tr>
<tr>
<td>烏亜篩検</td>
<td>輔導協助戒煙。對於吸煙的受益人，聯邦醫療保險承保 12 個月之內的 B 部分面對面輔導。</td>
</tr>
<tr>
<td>疫苗接種/ 預防注射</td>
<td>流感：每季流感季節可注射一次。肺炎：通常一生中只需要注射一次。第二針在注射第一針後 12 個月承保。乙肝：若是處於中高風險狀態可獲補償。</td>
</tr>
</tbody>
</table>

**CALL 311 AND ASK FOR HIICAP**

**14**
When a person has Medicare and other health insurance coverage, it is necessary to understand which insurance is primary, and which is secondary. The primary insurance is the one that will consider the claim first and the secondary insurance will consider any balance after the claim has been paid or denied by the primary insurance.

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

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

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

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

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.
At the time of retirement, the employee needs to consider enrolling in Medicare Part B, since

2.

Retirees have three choices:

1. Medicare Part B to cover some of the costs that the FEHB plan may not cover, but can make a decision to pay as primary if the individual does not enroll in Medicare. FEHB members should enroll in Medicare Part B when you understand how your retiree benefits coordinate with Medicare.

In cases where one has both Medicare and

Retiree health insurance, Medicare is primary and retiree coverage is secondary. For some, retiree health insurance coverage more like a Medicare Advantage plan. You must speak to the benefits administrator to retiree benefits work more like a supplement to Original Medicare, while for others it acts like an insurance plan. It is advised to retiree benefits to Medicare Parts A and/or B; it is advised to contact the employer about this issue.

At the time of retirement, the employee needs to consider enrolling in Medicare Part B, since Medicare Part B will be the primary insurance upon retirement. Enrollment in Medicare Part B should be done within 8 months of the end of active employment, not at the end of health care coverage, in order to avoid a possible gap in coverage and a late enrollment penalty. One will need the employer to complete a form, CMS-L564, documenting employer-based health insurance coverage. The form can be found at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-L564E.pdf

Retiree health coverage: Generally speaking, in cases where one has both Medicare and retiree health insurance, Medicare is primary and retiree coverage is secondary. For some, retiree benefits work more like a supplement to Original Medicare, while for others it acts like an insurance plan. It is advised to contact the employer about this issue.

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

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

2. FEHB and Part B. Members can continue with their FEHB coverage and enroll in Part B also. Some FEHB plans may provide an incentive to enroll in Medicare, such as reducing out-of-pocket costs and waiving FEHB plan co-payments, deductibles, and coinsurance. Members electing to participate in both Medicare and FEHB will need to pay both the FEHB and Part B premiums.

3. Part B and NO FEHB. Unlike most retirees, Federal retirees can SUSPEND (not cancel) their retiree coverage to enroll in a Medicare Advantage plan, which may have a lower monthly premium or no added premium at all. Individuals choosing this option will still need to enroll in Part B in order to enroll in a Medicare Advantage plan, but they will avoid the higher cost of the FEHB premium. Additionally, they may elect to return to FEHB coverage during the next FEHB Open Enrollment period.
CALL 311 AND ASK FOR HIICAP


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

End Stage Renal Disease (ESRD): Some individuals are eligible for Medicare Part B coverage because they have End Stage Renal Disease and are either receiving maintenance dialysis treatments or have had a kidney transplant. If there is an employer group health plan, it is primary during the first 30 months of Medicare eligibility. After 30 months, Medicare is primary.

Worker’s Compensation and Medicare: Worker’s Compensation is usually primary in the event of a job-related injury and covers only health care expenses related to the injury. Pre-existing conditions can be paid for by Medicare if Worker’s Compensation does not cover these conditions. In cases where the Workers Compensation plan does not pay promptly, Medicare may make a conditional payment; Medicare would then be reimbursed when the payment comes through. The Benefits Coordination & Recovery Center (BCRC) assists with this function.
MEDICARE SUPPLEMENT INSURANCE (Medigap)

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

Why do I need A Medigap policy?
A Medigap policy offers reimbursement for out-of-pocket health service costs not covered by Medicare, which are the beneficiary’s share of costs. For example, a Medigap policy might cover the Part A deductible, the Part B outpatient co-insurance of 20% of allowed charges, and other costs. Note that some plans only cover a percentage of these costs, while other plans cover them in full. Medicare Advantage plan enrollees should not enroll in a Medigap plan, as this would duplicate coverage they have through their Medicare Advantage plan.

What Medigap policies are available?
There are ten standard Medigap policies available, designated "A" through "N." Each of the policies covers the basic benefit package, plus a combination of additional benefits. Older Medigap policies from before the 1992 standardization are still in effect, but cannot be offered to new enrollees; individuals with these policies can maintain their existing coverage, but may wish to compare benefits with the premium cost to determine whether their plan remains cost effective.

Effective January 1, 2020, no Medigap Plan C or Plan F may be sold to a "newly eligible" Medicare beneficiary. A newly eligible Medicare beneficiary is defined as an individual who is not a person who: (1) has attained age 65 before January 1, 2020; or (2) was entitled to Medicare Part A benefits by disability or ESRD before January 1, 2020.

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

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

CALL 311 AND ASK FOR HIICAP

18
How do I choose a Medigap policy?
Since Medigap plans are standardized, you first need to decide the level of coverage you need. Once you establish which plan’s set of benefits is right for you, you can compare the premium, service and reputation of the insurance companies. Most Medigap insurers have linked their computers with the computers at Medicare, so that your claims can be processed without additional paperwork ("electronic crossover"). In addition, companies can bill the premium monthly, quarterly or annually; your preference may be for a particular payment schedule.

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

How are premiums determined?
In New York State, you are protected by “community rating.” The premium set by an insurance company for one of its standard Medigap policies is required to be the same without regard to age, gender or health condition. That means that the premium for Plan N from one insurance company will be the same for a woman, aged 72 in poor health as it will be for a man, aged 81, in good health. A chart of the ten standard plans follows the description of the plans. See page 23 for a listing of insurance companies and their premiums for Medicare beneficiaries in New York City.

When will my coverage start if I have a pre-existing health condition?
The maximum period that a Medigap policy’s coverage can be denied for a pre-existing health condition is the first six months of the new policy and only for those claims that are directly related to that health problem. A pre-existing condition is a condition for which medical advice was given, or treatment was recommended by, or received from, a physician within six months before the effective date of coverage. You may qualify for immediate coverage for a pre-existing health condition (1) if you buy a policy during the open enrollment period after turning 65 or (2) if you were covered under a previous health plan for at least six months without an interruption of more than 63 days. If your previous health plan coverage was for less than six months, your new Medigap policy must credit you for the number of months you had coverage. Some insurers have shorter waiting periods for pre-existing conditions. A chart with the waiting periods for pre-existing conditions can be found online at http://dfs.ny.gov/consumer/caremain.htm#sub_gen.

How do I choose a Medigap policy?
Since Medigap plans are standardized, you first need to decide the level of coverage you need. Once you establish which plan's set of benefits is right for you, you can compare the premium, service and reputation of the insurance companies. Most Medigap insurers have linked their computers with the computers at Medicare, so that your claims can be processed without additional paperwork ("electronic crossover"). In addition, companies can bill the premium monthly, quarterly or annually; your preference may be for a particular payment schedule.

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

How are premiums determined?
In New York State, you are protected by "community rating." The premium set by an insurance company for one of its standard Medigap policies is required to be the same without regard to age, gender or health condition. That means that the premium for Plan N from one insurance company will be the same for a woman, aged 72 in poor health as it will be for a man, aged 81, in good health. A chart of the ten standard plans follows the description of the plans. See page 23 for a listing of insurance companies and their premiums for Medicare beneficiaries in New York City.

When will my coverage start if I have a pre-existing health condition?
The maximum period that a Medigap policy's coverage can be denied for a pre-existing health condition is the first six months of the new policy and only for those claims that are directly related to that health problem. A pre-existing condition is a condition for which medical advice was given, or treatment was recommended by, or received from, a physician within six months before the effective date of coverage. You may qualify for immediate coverage for a pre-existing health condition (1) if you buy a policy during the open enrollment period after turning 65 or (2) if you were covered under a previous health plan for at least six months without an interruption of more than 63 days. If your previous health plan coverage was for less than six months, your new Medigap policy must credit you for the number of months you had coverage. Some insurers have shorter waiting periods for pre-existing conditions. A chart with the waiting periods for pre-existing conditions can be found online at http://dfs.ny.gov/consumer/caremain.htm#sub_gen.
What paperwork will I receive from my Medigap insurer?
A Medigap insurance company is required to send you an Explanation of Benefits to document that it paid its portion of your claims for your health benefits. Combined with the Medicare Summary Notice (MSN) which you receive from Medicare, you will have the total information about how your health care claim was processed.

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 ($341 per day in 2019) for days 61-90 of hospitalization in each Medicare benefit period.
• Coverage for the Part A copayment amount ($250 per day in 2019) 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 for the coinsurance amount for Part B services (generally 20% of approved amount), after the annual deductible is met ($185 in 2019).

PLAN B includes the basic benefit, plus
• Coverage for the Medicare Part A inpatient hospital deductible ($1,364 per benefit period in 2019).

PLAN C1 includes the basic benefit, plus
• Coverage for the Medicare Part A inpatient hospital deductible.
• Coverage for the skilled nursing facility care copayment amount ($170.50 per day for days 21 through 100 per benefit period in 2019).
• Coverage of the Medicare Part B deductible ($185 per calendar year in 2019).
• 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.

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 for the coinsurance amount for Part B services (generally 20% of approved amount), after the annual deductible is met ($185 in 2019).

CALL 311 AND ASK FOR HIICAP

1 Starting in 2020, a law takes effect restricting Medigap plans from covering the Part B deductible. See page 18 for more information.

我會從醫藥補充保險業者處收到什麼文件？
醫藥補充保險業者必須寄給您賠償證明，以文件證明其支付了您所提出的醫療理賠要求中由承保公司負責的部分。加入您從聯邦醫藥保險所收到的聯邦醫療保險摘要通知 (MSN)，您將擁有醫療理賠如何處理的全部資訊。

標準型醫療補充保險計畫
以下為十種標準型 Medigap 計畫，計畫 A 至 N，以及每個計劃所提供的賠付：

A 計畫（基本保單）含有下列基本賠付：
• 在每一段聯邦醫療保險權益期內第 61 至 90 天的住院治療，賠付 A 部分共付額 (2019 年為每天 $341)。
• 對於聯邦醫療保險不可續延的 60 天住院終身儲備期，每一天都提供 A 部分共保額賠付 (2019 年為每天 $250)。
• 在聯邦醫療保險的住院賠償全部用盡之後，對於聯邦醫療保險 A 部分的合格住院支出提供 100% 賠償。在保單持有人的一生中，追加住院治療的賠償上限為 365 天。
• 對聯邦醫療保險 A 部分安寧護理的費用分攤提供賠償。
• 依聯邦醫療保險 A 部分和 B 部分，每日每週的最多 3 組的紅血球濃縮液的合理費用提供賠償，除非是遵從聯邦規定而更換。
• 在達到年度自付額（2019 年為 $185）之後，為 B 部分服務的自付額提供賠償（一般為核准金額之 20%）。

B 計畫（包括基本賠償，另加）
• 對聯邦醫療保險 A 部分住院治療自付額提供賠償 (2019 年每一段權益期為 $1,364)。

C1 計畫（包括基本賠償，另加）
• 對聯邦醫療保險 A 部分住院治療自付額提供賠償。
• 對專業護理設施的共付額提供賠償（2019 年每一段權益期的第 21 至 100 天為每天 $170.50）。
• 對聯邦醫療保險 B 部分自付額提供賠償 (2019 年為每日額為 $185)。
• 對在國外接受的必要緊急治療提供 80% 賠償，唯須先扣除自付額 $250，而一生最高賠償上限為 $50,000。

D 計畫（包括基本賠償，另加）
• 對聯邦醫療保險 A 部分住院治療自付額提供賠償。
• 對專業護理設施的每日共付額提供賠償。
• 對在國外接受的必要緊急治療提供 80% 賠償，唯須先扣除自付額 $250，而一生最高賠償上限為 $50,000。

1 自 2020 年開始，相關法律將生效，並限制醫療補充保險計畫承保 B 部分自付額。詳情請參見第 18 頁，
PLAN F\(^1\) includes the **basic benefit**, plus
- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges, also known as limiting charge\(^2\).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible and $50,000 lifetime maximum benefit.

**PLAN F+ (high deductible)**
- Same benefits as the Standard Plan F, but you will have to pay a $2,300 deductible in 2019 before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums.

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

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

PLAN K\(^1\) 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.

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

3 The basic benefits for plans K, L, M and N include similar services as plans A-G, but the cost-sharing for the basic benefits is at different levels. The annual out-of-pocket limit can increase each year for inflation.
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 100% of the skilled nursing facility care daily coinsurance amount.
• Annual out-of-pocket limit of $2,780 in 2019.

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.

Members of some organizations are able to purchase Medigap insurance at discounted rates. Check with any organizations to which you belong that may offer this as an option.

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

CALL 311 AND ASK FOR HIICAP

L 計劃包括基本賠付，另加
• 對聯邦醫療保險 A 部分住院治療自付額提供 75% 賠付。
• 對 B 部分自付額提供 75% 賠付，惟須先支付聯邦醫療保險 B 部分的年度自付額；不過，B 部分預防性醫療服務的自付額可獲得 100% 賠付。
• 對每一段聯邦醫療保險權益期內住院治療第 61 天至 90 天的 A 部分共付額提供 100% 賠付。
• 對於聯邦醫療保險不可諭延的 60 天住院終身儲備額，為榨用之每一天的 A 部分共付額提供 100% 賠付。
• 在聯邦醫療保險的住院賠付全部用盡之後，對於聯邦醫療保險 A 部分的合格住院支出提供 100% 賠付。在保單持有人的一生中，加住院治療的賠付上限為 365 天。
• 對安寧療護的費用分攤提供 75% 賠付。
• 對符合聯邦醫療保險條件的最初 3 品舶血虜費用提供 75% 賠付。
• 對專業護理設施的每日共付額提供 75% 賠付。
• 2019 年的年度自付費用限額為 $2,780。

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

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

某些組織成員可以折扣價格購買補充險。請向您所屬的組織確認是否提供此服務選項。

3 K・L・M 和 N 計劃內的基本賠付與 A 至 G 計劃包括的醫療服務相類，但對基本賠付的分攤費用則屬不同級別，年度自付費用限額可因通貨膨脹而每年調整。 請致電 311 諮詢 HIICAP
**BENEFITS INCLUDED IN THE TEN STANDARD MEDICARE SUPPLEMENT PLANS**

**Basic Benefit:** Included in all plans

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

**Basic Benefit:** Included in all plans

<table>
<thead>
<tr>
<th>Plan</th>
<th>Basic Benefit</th>
<th>Basic Benefit</th>
<th>Basic Benefit</th>
<th>Basic Benefit</th>
<th>Basic Benefit</th>
<th>Basic Benefit</th>
<th>Basic Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
</tr>
<tr>
<td>B</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
</tr>
<tr>
<td>C</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
</tr>
<tr>
<td>D</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
</tr>
<tr>
<td>E</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
</tr>
<tr>
<td>F</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
<td>Basic Benefit</td>
</tr>
</tbody>
</table>

**Skilled Nursing Coinurance:**
- **Part A Deductible**
  - Part A Deductible (50%)
  - Part A Deductible (75%)

**Part B Deductible**
- Part B Deductible
- Part B Excess

**Foreign Travel Emergency**
- Foreign Travel Emergency
- Foreign Travel Emergency

<table>
<thead>
<tr>
<th>Out of Pocket Limit</th>
<th>Out of Pocket Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,560</td>
<td>$2,780</td>
</tr>
</tbody>
</table>

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

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

**CALL 311 AND ASK FOR HIICAP**

---

**10種標準型醫療補充保險計畫所包含的給付**

**基本給付：**包含在所有的計畫內

- **住院療養：**A 部分共付額，在聯邦醫療補充保險終止後提供 365 天給付，並對 60 天的終身儲備額額共付額提供給付。
- **醫療費用：**B 部分共付額 （一般為聯邦醫療補充保險費用之 20%）
- **血漿：**每年的前三個月的血液費用。
- **安寧療護：**A 部分的給付費用。

<table>
<thead>
<tr>
<th>計畫</th>
<th>基本給付</th>
<th>基本給付</th>
<th>基本給付</th>
<th>基本給付</th>
<th>基本給付</th>
<th>基本給付</th>
<th>基本給付</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>B</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>C</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>D</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>E</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>F</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>G</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>K</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>L</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>M</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
<tr>
<td>N</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
<td>基本給付</td>
</tr>
</tbody>
</table>

**A 部分自付額：**
- A 部分自付額
- A 部分自付額
- A 部分自付額
- A 部分自付額
- A 部分自付額
- A 部分自付額

**B 部分自付額：**
- B 部分自付額
- B 部分自付額
- B 部分自付額

**C 部分自付額：**
- C 部分自付額

**D 部分自付額：**
- D 部分自付額

**F 計畫亦提供高自付額選項可供選擇。**

**這些計畫均含基本給付，但是費用分攤條件不一。**

**請致電 311 請問 HIICAP**

---
MEDICARE SUPPLEMENT INSURANCE POLICIES

Prepared by the NYC Department for the Aging’s Health Insurance Information Counseling Assistance Program (HIICAP) 1-212-602-4180. Please call the individual companies directly for their most current monthly rates as they are subject to change. Updated rate charts are available at the NY State Department of Insurance website at http://www.dfs.ny.gov/consumer/medplan/medsup19.pdf.

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

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

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

### Rates effective January 2019

**Medicare Supplement Insurance Policies**

- **Ae**: 800-345-6022
- **Bankers Conseco**: 800-845-5512
- **Empire Blue Cross Blue Shield**: 855-731-1090
- **Globe Life Insurance**: 800-444-2333
- **HI Humana**: 800-486-2620
- **Mutual of Omaha (AARP)**: 800-228-9999

**AARP**

- **A**: $318.21
- **B**: $362.44
- **C**: $372/417
- **D**: $367/411
- **F**: $422.90
- **F+**: $75.69
- **G**: $357.12
- **K**: $99.74
- **L**: $274.69
- **M**: $380.44
- **N**: $332.32

**Mutual of Omaha (AARP)**

- **A**: $318.21
- **B**: $362.44
- **C**: $372/417
- **D**: $367/411
- **F**: $422.90
- **F+**: $75.69
- **G**: $357.12
- **K**: $99.74
- **L**: $274.69
- **M**: $380.44
- **N**: $332.32

**HI Humana**

- **A**: $352.25
- **B**: $460.47
- **C**: $372/417
- **D**: $372/417
- **F**: $621.64
- **G**: $572.17
- **K**: $138/154
- **L**: $194/217
- **M**: $380.44
- **N**: $332.32

**Globe Life Insurance (AARP)**

- **A**: $252/252
- **B**: $235
- **C**: $412.76
- **D**: $491.66
- **F**: $421.13
- **G**: $466.43
- **K**: $196.68
- **L**: $280.85
- **M**: $478.89
- **N**: $421.13

**United Health (AARP)**

- **A**: $252/252
- **B**: $235
- **C**: $412.76
- **D**: $491.66
- **F**: $421.13
- **G**: $466.43
- **K**: $196.68
- **L**: $280.85
- **M**: $478.89
- **N**: $421.13

**Prepared by the NYC Department for the Aging’s Health Insurance Information Counseling Assistance Program (HIICAP)**

- **A**: 800-345-6022
- **Bankers Conseco**: 800-845-5512
- **Empire Blue Cross Blue Shield**: 855-731-1090
- **Globe Life Insurance**: 800-444-2333
- **HI Humana**: 800-486-2620
- **Mutual of Omaha (AARP)**: 800-228-9999

**AARP**

- **A**: $318.21
- **B**: $362.44
- **C**: $372/417
- **D**: $367/411
- **F**: $422.90
- **F+**: $75.69
- **G**: $357.12
- **K**: $99.74
- **L**: $274.69
- **M**: $380.44
- **N**: $332.32

**Mutual of Omaha (AARP)**

- **A**: $318.21
- **B**: $362.44
- **C**: $372/417
- **D**: $367/411
- **F**: $422.90
- **F+**: $75.69
- **G**: $357.12
- **K**: $99.74
- **L**: $274.69
- **M**: $380.44
- **N**: $332.32

**HI Humana**

- **A**: $352.25
- **B**: $460.47
- **C**: $372/417
- **D**: $372/417
- **F**: $621.64
- **G**: $572.17
- **K**: $138/154
- **L**: $194/217
- **M**: $380.44
- **N**: $332.32

**Globe Life Insurance (AARP)**

- **A**: $252/252
- **B**: $235
- **C**: $412.76
- **D**: $491.66
- **F**: $421.13
- **G**: $466.43
- **K**: $196.68
- **L**: $280.85
- **M**: $478.89
- **N**: $421.13
MEDICARE ADVANTAGE PLANS
HMO, PPO, HMO-POS, SNP

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

To be eligible to join a Medicare Advantage plan, you must have both Medicare Part A and Part B (and pay the Part B premium); you must live in the plan’s service area; and you cannot have end stage renal disease (ESRD). A Medicare Advantage plan cannot turn away an applicant because of health problems, other than ESRD.

Joining a Medicare Advantage plan is a choice. Every Medicare Advantage plan must provide its members with all of the same medically necessary services that "Original" Medicare Part A and Part B cover, and typically include additional services, such as a prescription drug benefit, vision, dental and hearing services. If you wish to have Medicare Part D prescription drug coverage and belong to a Medicare Advantage plan, you must get the Part D drug coverage through your plan; you cannot join a separate Part D plan. All Medicare beneficiaries have the right to obtain the needed medical services, to get full information about treatment choices from their doctor, and to appeal any denial of services or reimbursement made by a Medicare Advantage plan.

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

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

HMO, PPO, HMO-POS, and SNP plans involve a network of doctors, health centers, hospitals, skilled nursing facilities and other care providers for the enrolled member to use for their medical needs. Medicare Advantage plans’ networks can be local, statewide, and even national. It is important to contact the plan to understand the scope of the provider network, especially if you travel and may require care other than emergency care outside your area of residence.

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險優勢計畫
HMO - PPO - HMO-POS - SNP

聯邦醫療保險優勢計畫為紐約市的受益人提供「原創」聯邦醫療保險之外的選擇。聯邦醫療保險優勢計畫是由民間公司提供，以提供健康維護組織 (HMO)、優選醫療機構計畫 (PPO)、健康維護組織+療點服務 (HMO-POS)、特殊需求計畫 (SNP) 給聯邦醫療保險受益人。這些公司從聯邦醫療保險和醫療補助服務中心 (CMS) 收到月度固定付款，以提供聯邦醫療保險福利給投保者。

欲符合參加聯邦醫療保險優勢計畫的資格，您必須同時擁有聯邦醫療保險 A 部分和 B 部分 (以及支付 B 部分保費)；必須居住在該計畫的服務地區；並且不能患有末期腎臟疾病（ESRD）。聯邦醫療保險優勢計畫不得因 ESRD 以外的健康問題而拒絕申請人加入。

加入聯邦醫療保險優勢計畫是一項選擇，每項聯邦醫療保險優勢計畫都必須提供與聯邦醫療保險原始計畫 A 部分和 B 部分所承保之相同的必要醫療服務予其會員，並且通常包含更多服務，例如處方藥保單、眼科、牙科及聽力服務。若您希望有聯邦醫療保險 D 部分處方藥保單，並且已加入聯邦醫療保險優勢計畫，您必須透過該計畫取得 D 部分藥品保險；您不能加入單獨的 D 部分計畫。所有的聯邦醫療保險受益人都有權利取得所須的醫療服務、從醫生處獲得關於治療選擇的充分資訊，並且就聯邦醫療保險優勢計畫所豁免的任何服務或價款提出申訴。

如果您加入聯邦醫療保險優勢計畫，您不能購買 Medigap 藥物補償保單，因為這會造成重複承保。

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

HMO - PPO - HMO-POS 和 SNP 計畫是由醫生、保健中心、醫院、專業護理設施和其他護理業者所構成的網路。為國內會員提供護理服務，聯邦醫療保險優勢計畫的網路可以是當地的、全州、甚至全國性的，實際聯繫該計畫以瞭解醫療業者網絡的區域範圍是重要的，尤其是當您出外旅行而可能會在您居住以外的地區接受非緊急性醫療照護時更是如此。
HMOs require the Medicare beneficiary to select a primary care physician (PCP) from the HMO's network of local doctors. You have a choice of physician, provided he or she has availability for new patients. Some HMOs require that the PCP provide a referral to specialists. You must receive your health care from the HMO's network of providers and hospitals. Except for emergency care, there is no coverage for services obtained out-of-network; the beneficiary will be responsible for the full costs of such services. An HMO may offer additional benefits to those offered in fee-for-service Medicare, such as hearing aids, vision and dental care.

PPOs provide a network of health care providers and hospitals but do not restrict the enrollee from going out-of-network. The PPO sets its payment to in-network providers with a fixed co-pay from the enrollee; enrollees will pay more for services from out-of-network providers. (Out-of-network providers are subject to Medicare's limiting charge, with a fixed co-pay from the enrollee; enrollees will pay more for services from out-of-network providers. (Out-of-network providers are subject to Medicare's limiting charge, which limits the amount they can charge a Medicare beneficiary for services.)

HMO with Point-Of-Service Option (HMO-POS) is similar to a PPO plan. It provides greater flexibility than an HMO because members may use both in-network and out-of-network providers. However, HMO-POS plans may not cover all benefits out-of-network. For example, a plan may only offer in-network inpatient hospital coverage. Contact the plan for details.

Special Needs Plans (SNP) are Medicare Advantage plans (HMOs or PPOs) that are available only to certain groups of people with Medicare. Examples of people who might be eligible to join a Medicare Advantage SNP include: people with both Medicare and Medicaid; people with certain chronic conditions; and people living in an institution, such as a nursing home. Coverage includes services covered by Medicare Parts A and B, as well as 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 when first eligible can be done online at www.MEDICARE.gov, by calling 1-800-medicare, or by contacting the plan directly. It is important to know the timing for enrolling in a Medicare Advantage plan:

- When you become Medicare eligible due to turning 65, you can enroll in a Medicare Advantage plan through the end of your 7-month Initial Enrollment Period (IEP), which ends 3 months after the month in which you turn 65.
  - If you sign up for a Medicare Advantage plan during this time, you can drop that plan at any time during the next 12 months and switch to Original Medicare.
- When you become Medicare eligible due to disability, you can enroll in a Medicare Advantage plan starting three months prior to the effective start date of Medicare, and ending three months after the start of Medicare benefits.
- If you enroll in Medicare during the General Enrollment Period (GEP), you have between April 1- June 30 to select a Medicare Advantage plan.

CALL 311 AND ASK FOR HIICAP
There are several opportunities to change or leave your Medicare Advantage plan:

• From October 15-December 7, you can change your Medicare Advantage (MA) plan or return to Original Medicare, with the change effective January 1. You can do this by calling 1-800-MEDICARE, enrolling online at www.medicare.gov, or by calling the plan in which you want to enroll.

• From January 1 – March 31, Medicare Advantage enrollees have one additional opportunity to either switch to a different Medicare Advantage plan or return to original Medicare, with the change effective the first of the following month, either February 1, March 1, or April 1. To make this change, simply enroll in the plan in which you want to enroll by calling the plan directly, or 1-800-MEDICARE; this enrollment will automatically disenroll you from the other Medicare Advantage plan.

• In you enrolled in a Medicare Advantage plan during your 7-month Initial Enrollment Period, you can change to another Medicare Advantage plan or switch to Original Medicare within the first 3 months you have Medicare.

• 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.

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

Tips for Switching Between Original Medicare and Medicare Advantage

- Medicare Advantage → 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 → Medicare Advantage: Enroll in the desired Medicare Advantage plan (this will trigger disenrollment from the original MA plan).

- Original Medicare → Medicare Advantage: Enroll in the desired Medicare Advantage plan (this will trigger disenrollment from your Part D plan that works with Original Medicare). You may wish cancel your supplemental coverage.

You have several opportunities to change or leave your Medicare Advantage plan:

• From October 15-December 7, you can change your Medicare Advantage (MA) plan or return to Original Medicare, with the change effective January 1. You can do this by calling 1-800-MEDICARE, enrolling online at www.medicare.gov, or by calling the plan in which you want to enroll.

• From January 1 – March 31, Medicare Advantage enrollees have one additional opportunity to either switch to a different Medicare Advantage plan or return to original Medicare, with the change effective the first of the following month, either February 1, March 1, or April 1. To make this change, simply enroll in the plan in which you want to enroll by calling the plan directly, or 1-800-MEDICARE; this enrollment will automatically disenroll you from the other Medicare Advantage plan.

• In you enrolled in a Medicare Advantage plan during your 7-month Initial Enrollment Period, you can change to another Medicare Advantage plan or switch to Original Medicare within the first 3 months you have Medicare.

• 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.

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

Tips for Switching Between Original Medicare and Medicare Advantage

- Medicare Advantage → 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 → Medicare Advantage: Enroll in the desired Medicare Advantage plan (this will trigger disenrollment from the original MA plan).

- Original Medicare → Medicare Advantage: Enroll in the desired Medicare Advantage plan (this will trigger disenrollment from your Part D plan that works with Original Medicare). You may wish cancel your supplemental coverage.

CALL 311 AND ASK FOR HIICAP

27
Frequently Asked Questions about Medicare Advantage Plans

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

All Medicare Advantage Plans are required to have an 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 costs in a given calendar year. In 2019, maximum out-of-pocket costs (MOOP) cannot exceed $6,700 in-network for HMO plans and $10,000 combined in-network and out-of-network for PPO plans.

What about emergency services?
Emergency medical care will be covered by the Medicare Advantage plan provided that the provider of services first, and then file a claim with the plan for reimbursement. If the notification was faulty, it may refuse to cover the costs.

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

How do I complain about quality of care?
If your complaint is related to the quality of health care you receive, you should follow your plan’s grievance procedures. You can also present your case to the Medicare Quality Improvement Organization (QIO). Livanta, LLC, in New York State, whose doctors and other professionals review the care provided to Medicare patients. Livanta can be reached at 1-866-915-5440.

Obtaining Services in Original Medicare vs. Medicare Advantage
In Original Medicare, the beneficiary obtains all medically-needed services from any Medicare provider anywhere in the United States. Medicare sets the fees for those services and covers 80% of most costs. The beneficiary is responsible for the balance. Medicare supplement insurance, also known as Medigap (see page 18), can cover all or most of the senior’s share of the costs. Medicare Advantage plans are managed care plans, and operate very differently, with their own cost structure that can include premiums, deductibles, co-payments and maximum out-of-pocket costs.

CALL 311 AND ASK FOR HIICAP

關於聯邦醫療保險優勢計畫的常見問題

在聯邦醫療保險優勢計畫中的自付費用為何？
聯邦醫療保險優勢計畫會設置其各自的保費和費用分攤方案。除了每月聯邦醫療保險B 部分保費之外，您可以用自付費的方式另外直接付予該計畫。所有費用分攤規定都必須在您的保險卡上或保險卡附説明中清楚說明。若有不確定之處，請致電該計畫，保健服

務可能會有共付額、共保額及自付額，確保您了解主診訪診、專科醫生訪診、住院病人住

院、處方藥的不同自付費用以及您可能得支付的其他費用。

對於 A 部分和 B 部分所承保的全部服務，所有的聯邦醫療保險優勢計畫都需要有每年自付

費用的最高限，對您在每一日曆年所負擔的自付費用設定限額。2019 年，HMO 計畫網

路的自付費用最高限 (MOOP) 不得超過 $6,700，而 PPO 計畫結合網內及網外的最高

限為 $10,000。

對急診服務的保障呢？
只要遵照通知規定並獲得核准，緊急醫療護理將能得到聯邦醫療保險優勢計畫的賠付。您

可能需要先支付費用予醫療機構，然後再向該計畫申請賠償款。若該決定判定醫療護理需

求不符合其條件，或是通報不實，則可能拒絕賠付該費用。

我如何對醫護品質提出投訴？
若投訴是關於您所收到的醫護品質，應遵照您的保險計畫的陳情程序。您也可向紐約州的

聯邦醫療保險品質改變組織 (QIO) Livanta, LLC 提交您的投訴。Livanta 的醫生及其他專業

人士會審為聯邦醫療保險病人所提供的醫療護理。可致電 1-866-815-5440 聯繫 Livanta。
How should I decide whether to join a Medicare Advantage plan and which plan may be right for me?

Consideration should be given to the following areas before joining a plan: Your current doctors’ participation in the plan; hospitals’ participation in the plan; prescription drug coverage; finances; and geographical location. It is vital to review this information each year during the Annual Election Period (October 15 – December 7).

1. **Your doctors’ participation in the plan:** Ask your doctors what plans they participate in and whether they are accepting new Medicare patients under that particular plan. Even if you already have an established relationship with that doctor, you need to be certain that they will accept you as a new patient under that particular plan. Confirm provider participation each year.

2. **Preferred hospital(s) participation in the plan:** Make sure that any hospitals you use, and any that you would like to have access to, participate in the plan, or would allow you to access the hospital on an out-of-network basis.

3. **Prescription drugs:** Check how the plan would cover your prescription drugs (formulary, restrictions, cost).

4. **Finances:** Receiving care through a Medicare Advantage plan may cost you less than receiving care through original Medicare. Medicare Advantage plans may cover services which are not covered by original Medicare, such as routine vision and dental care, as well as hearing aids. It is important to research the fee structure (premium, copays, deductible, maximum out-of-pocket costs, etc.) in a Medicare Advantage plan before enrolling.

5. **Geographical Location:** It is important to think about your travel plans when deciding whether an HMO plan is right for you. Because HMO plans have defined geographic areas that they serve, if you plan to be outside of the service area for any length of time, an HMO may not be right for you, since only emergency care is covered outside the plan’s service area. The service areas of PPO and HMO-POS plans are less restrictive, but you should still be aware of the plan’s service area.

Will I need a Medicare supplement insurance policy?

You will not need a Medicare supplement insurance policy ("Medigap") if you join a Medicare Advantage plan, as Medigap coverage would duplicate your benefits. If you decide to join a Medicare Advantage plan, and you already have a Medigap policy, you may want to retain it for at least 30 days, until you see if the Medicare Advantage plan is satisfactory. By New York State law, you will always be able to purchase a Medigap policy if you leave a Medicare Advantage plan and return to original Medicare, but you may face a period of non-coverage for a current health condition if you have a gap in coverage.

For more about Medigap, see page 18.

CALL 311 AND ASK FOR HIICAP

Will I need a Medicare supplement insurance policy?

You will not need a Medicare supplement insurance policy ("Medigap") if you join a Medicare Advantage plan, as Medigap coverage would duplicate your benefits. If you decide to join a Medicare Advantage plan, and you already have a Medigap policy, you may want to retain it for at least 30 days, until you see if the Medicare Advantage plan is satisfactory. By New York State law, you will always be able to purchase a Medigap policy if you leave a Medicare Advantage plan and return to original Medicare, but you may face a period of non-coverage for a current health condition if you have a gap in coverage.

For more about Medigap, see page 18.
MEDICARE PART D – PRESCRIPTION DRUG COVERAGE

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

Medicare prescription drug plans are available to all people with Medicare (Part A and/or Part B). A result of the Medicare Modernization Act of 2003, Medicare Part D adds prescription drug coverage benefits to Medicare’s existing health benefits of Part A (hospitalization), Part B (outpatient services), and Medicare Advantage Plans. Part D is an optional and voluntary benefit; Medicare beneficiaries are not required to join a plan, although there may be a penalty for late enrollment.

Medicare Part D is unlike Parts A or B, as it is not standardized nationally but instead is offered through private-sector companies. Each private company designs its own plan for Medicare consumers. These plans have all entered into a contract with the federal government to provide Medicare Part D drug coverage through the Centers for Medicare and Medicaid Services (CMS) which regulates the plans and categories of covered drugs. When you sign up for a Part D plan, you are applying directly to a private company who negotiates the costs of your drugs with pharmacies, and has its own list of covered medications (formulary) and participating pharmacies, as well as its own procedures for getting a new drug covered or appealing to have a medication covered to meet your own special needs.

Medicare Part D is offered in one of two ways:

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

2. **Medicare Advantage Prescription Drug Plans (MAPDs):** these are managed care plans, such as HMOs, PPOs, HMO-POS, or SNPs, which offer comprehensive benefits packages that cover all of the following: hospital, doctors, specialists, pharmacy and prescriptions. If you are in a Medicare Advantage plan and want to have Part D coverage, you must get Part D coverage through your Medicare Advantage plan.

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

Beneficiaries with higher incomes (above $85,000 for an individual or $170,000 for a couple) will pay a surcharge for Part D in addition to their plan premium. The surcharge ranges from $12.40 to $77.40 per month in 2019, and may be paid in the same way as the Part B premium, typically as a deduction from one’s Social Security check (see page 68 for rate chart), but may be paid directly to the Part D insurer.

CALL 311 AND ASK FOR HIICAP
Although Part D plans’ benefit designs vary, they each include the following minimum levels of coverage in 2019:

- **Deductible** (up to $415). 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 $3,820 in total drug costs. (Total drug costs include the amount that you pay for the drug plus the amount that the plan pays for the drug.)
- **Coverage Gap** (also known as the “donut hole”). After $3,820 in total drug costs, you pay about 25% of brand name drug costs and 37% of generic drug cost (plus a nominal pharmacy dispensing fee), until you have incurred $5,100 in out-of-pocket costs. This includes the deductible (if any) plus any co-payments or coinsurance paid while reaching the coverage gap, the entire cost of brand name drugs purchased in the coverage gap, and the out-of-pocket costs for generic drugs purchased in the coverage gap.
- **Catastrophic Coverage** (after $5,100 in out-of-pocket expenses). The beneficiary is responsible for the greater of five percent (5%) of drug costs or a copay of $3.40 for generic medications and $8.50 for brand-name drugs.

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

**Enrollment in Medicare Part D**

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

Enrollment in Part D can occur during one’s seven-month Initial Enrollment Period (IEP), (see page 5). In addition, a beneficiary may join or change plans once each year between October 15 and December 7, during the Annual Coordinated Election Period (AEP). There are also limited exceptions where a beneficiary would be granted a Special Enrollment Period (SEP) to enroll in a Medicare Prescription Drug Plan or to switch plans outside of the AEP. These include the following situations:

- 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.
- Between January 1 – March 31, if you are in a Medicare Advantage plan with Part D, you can make a change to either a different Medicare Advantage plan, or to Original Medicare with or without Part D drug coverage.

### D部分計劃的保險賠付設計互異，但在 2019 年每項計劃都包含下列最起碼的承保內容：

- **自付額**（最高至 $415），這就是您在您的計劃幫助支付藥物費用之前需要自付的金額。有些計劃的自付額較低或無額自付額。
- **初次承保範圍**，固定共付額為藥費的 25%，藥品費用總額的最高限為 $3,820。（藥品費用總額包括自付的藥品費用金額加上該計劃支付的藥品費用金額。）
- **保障缺口**（亦即「空窗部分」），藥品費用總額達到 $3,820 之後，您大約支付 25% 的原廠品牌藥費用和 37% 的非原廠同藥費用（額外自費）收取藥費費用費），直$5,100 為止。此包括自付額的費額加上即將達到保障缺口時的任何共付額，共保額，在保障缺口期間購買原廠品牌藥的全部費用，以及在保障缺口期間購買非原廠等同藥的自付費用。
- **重大傷病豁免**（自付費用達 $5,100 之後），受益人必須自行負擔以下金額較大者：5% 的藥品費用，或 $3.40 的非原廠等同藥共付額及 $8.50 的原廠品牌藥共付額。

保障缺口正在逐步降低。2020 年，對於原廠品牌藥和非原廠等同藥，將會有一個固定的 25%共付額，直至達到重大傷病豁免額為止。

### 登記加入聯邦醫療保險 D 部分

登記加入聯邦醫療保險處方藥保險需要選擇提供與聯邦醫療保險原始計劃合作的聯邦醫療保險處方藥計劃（PDP）或聯邦醫療保險處方藥計畫（MA-PD），可上網查詢兩者的比較：www.medicare.gov 或致電 1-800-MEDICARE。您也可以致電 311 聯絡 HIICAP 以尋求協助。

可在 7 個月的首次參加期（IEP）期間登記加入 D 部分，（請見第 5 頁），而且，在每年 10 月 15 日至 12 月 7 日的年度協調選擇期（AEP）期間，受益人可以加入或更改計劃一次。受益人也有可能獲准在年度協調選擇期之外的特殊參加期（SEP）登記加入聯邦醫療保險處方藥計劃或轉換計劃，此為極有限的例外情況，其中包括以下情況：

- 已投保療害補助，聯邦醫療保險免費診治計劃或額外補助的人士可以在當年度的前 9 個月（1 月至 3 月；4 至 6 月；7 至 9 月）期間每季轉換計劃一次，而且變更會在下個月 1 日生效。
- EPIC 會員在日曆年內可更改 D 部分計劃一次。
- 在 1 月至 3 月 31 日期間，如果您已投保包含 D 部分的聯邦醫療保險處方藥計劃，則可以變更為不同的聯邦醫療保險處方藥計劃，或是轉換至包含或不包含 D 部分藥品保險的聯邦醫療保險原始計劃。

CALL 311 AND ASK FOR HIICAP

請致電 311 洽詢 HIICAP
• Change in county of residence where one has new Part D plan choices. (This SEP also includes individuals returning to the USA after living abroad and those released from prison.)
• Individuals entering, residing in, or leaving a long-term care facility, including skilled nursing facilities.
• Individuals disenrolling from employer/union-sponsored coverage, including COBRA, to enroll in a Part D plan.
• Prescription drug plan withdrawal from service area.

You can apply to join a Medicare Part D plan in several ways:
• Electronically on the internet, either through www.medicare.gov or the plan’s website. HIICAP can assist you with online enrollment.
• Over the telephone by calling 1-800-MEDICARE or by calling the plan directly.
• In person, through a Part D plan’s representative, during a scheduled home visit.

Late enrollment penalty
Even if a person with Medicare does not currently use a lot of prescription drugs, he or she should still consider purchasing a Part D plan. If a beneficiary does not have creditable coverage (coverage for prescription drugs that is at least as good as the standard Medicare prescription drug coverage), they will have to pay a penalty if they choose to enroll later. The penalty is equivalent to one percent (1%) of the base premium ($33.19 in 2019) per full month that the person with Medicare was not enrolled in a Medicare prescription drug plan when first eligible, and did not have creditable coverage. This penalty needs to be paid for as long as you have Part D coverage. If the beneficiary has had creditable coverage with a gap of no more than 63 days from when that coverage ended and the Medicare Part D coverage begins, they will not be subject to a penalty. There is no late enrollment penalty for people with full or partial Extra Help.

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

Do I need a Part D plan if I have employer health coverage?
You may not need to enroll in a Part D plan if you have creditable drug coverage through a current or former employer. The current or former employer should advise you, usually through a letter, as to whether your drug coverage is "creditable" and whether or not you should enroll in a Part D plan. If you do not receive a letter, contact the employer to determine if you should enroll in a Part D plan. This is vital, since enrollment in a Part D plan may compromise all health benefits through that employer, not just prescription drug coverage.
To select a Part D plan, it is best to use the personalized Planfinder tool at www.medicare.gov. You can either do a personalized search, whereby you input your personal Medicare information, or a general search, where you only include your zip code.

Follow the Planfinder prompts and input the names of the medications you are currently taking or expect to take in the upcoming year, along with the dosages and quantities needed for a 30-day supply. It is best to ask for a listing of your medications from your pharmacist before you start this process.

You will be asked to select up to two pharmacies that you would like to include in your search. After you have input all of the information, the plan finder will allow you to select which plans you would like to view—either Part D plans that work with Original Medicare, or Medicare Advantage Plans. The listing sorts the plans from least expensive to most expensive. It is important to look at the details of each plan to understand what restrictions, if any, may apply. It is also advised to call up the plan to verify the information.

When you have selected the plan that’s right for you, you can enroll online or by calling Medicare (1-800-MEDICARE) or the Part D plan. If you would like help using the plan finder, please contact a HICAP counselor by calling 311 and asking for HICAP.
Extra Help with Drug Plan Costs for People with Limited Incomes

The Social Security Administration (SSA), through which people sign up for Medicare Parts A and B, subsidizes the cost of a Part D plan for Medicare beneficiaries with lower incomes and limited resources. The subsidy is paid directly to the Part D plan. The program is called the Low-Income Subsidy Program (LIS), also known as Extra Help.

Full Extra Help is for beneficiaries with monthly incomes up to 135% of the Federal Poverty Level, $1,386 for an individual/$1,872 for couples in 2018 (estimated to be $1,405 individual/$1,902 couples in 2019), and resources up to $9,230 for individual/$14,600 for couples in 2019. These resource amounts include an additional $1,500 for individuals and $3,000 for couples for funeral or burial expenses.

Benefits of Full Extra Help:
- No monthly premium for a Part D plan, as long as the plan selected is a “benchmark” plan, a Basic plan that has a monthly premium that is fully subsidized by Extra Help (monthly premium up to $39.33 in 2019).
- No deductible.
- Reduced co-pays, depending on income - beneficiaries with incomes up to 100% of the Federal Poverty Level will have co-pays of $1.25 for generic and $3.80 for brand name prescriptions. All others with full Extra Help will have co-pays limited to $3.40 for generic and $8.50 for brand name prescriptions.

Partial Extra Help is for beneficiaries with monthly incomes up to 150% of the Federal Poverty Level, $1,538 for an individual/$2,078 for couples in 2018 (estimated to be $1,561 individual/$2,113 couples in 2019), and resources up to $14,390 for an individual/$28,720 for couples in 2019. These resource amounts include an additional $1,500 for individuals and $3,000 for couples for funeral or burial expenses.

Benefits of Partial Extra Help:
- Monthly plan premium on a sliding scale based on income.
- Deductible reduced to not more than $85.
- Reduced co-pays – pay the lower of 15% of drug costs or the plan’s cost-sharing.

HIICAP counselors can help screen for eligibility for Extra Help, as can the Social Security Administration. To apply for Extra Help, call SSA at 1-800-772-1213 (1-800-325-0778 TTY), or apply online at www.socialsecurity.gov. You may apply for Extra Help at any time of the year, and if you qualify, you will receive a Special Enrollment Period for selecting a Medicare Part D drug plan, and you may change your Part D plan at any time of the year. Individuals with Extra Help will not be subject to a late enrollment penalty in Part D.

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

CALL 311 AND ASK FOR HIICAP

Extra Help with Drug Plan Costs for People with Limited Incomes

The Social Security Administration (SSA), through which people sign up for Medicare Parts A and B, subsidizes the cost of a Part D plan for Medicare beneficiaries with lower incomes and limited resources. The subsidy is paid directly to the Part D plan. The program is called the Low-Income Subsidy Program (LIS), also known as Extra Help.

Full Extra Help is for beneficiaries with monthly incomes up to 135% of the Federal Poverty Level, $1,386 for an individual/$1,872 for couples in 2018 (estimated to be $1,405 individual/$1,902 couples in 2019), and resources up to $9,230 for individual/$14,600 for couples in 2019. These resource amounts include an additional $1,500 for individuals and $3,000 for couples for funeral or burial expenses.

Benefits of Full Extra Help:
- No monthly premium for a Part D plan, as long as the plan selected is a “benchmark” plan, a Basic plan that has a monthly premium that is fully subsidized by Extra Help (monthly premium up to $39.33 in 2019).
- No deductible.
- Reduced co-pays, depending on income - beneficiaries with incomes up to 100% of the Federal Poverty Level will have co-pays of $1.25 for generic and $3.80 for brand name prescriptions. All others with full Extra Help will have co-pays limited to $3.40 for generic and $8.50 for brand name prescriptions.

Partial Extra Help is for beneficiaries with monthly incomes up to 150% of the Federal Poverty Level, $1,538 for an individual/$2,078 for couples in 2018 (estimated to be $1,561 individual/$2,113 couples in 2019), and resources up to $14,390 for an individual/$28,720 for couples in 2019. These resource amounts include an additional $1,500 for individuals and $3,000 for couples for funeral or burial expenses.

Benefits of Partial Extra Help:
- Monthly plan premium on a sliding scale based on income.
- Deductible reduced to not more than $85.
- Reduced co-pays – pay the lower of 15% of drug costs or the plan’s cost-sharing.

HIICAP counselors can help screen for eligibility for Extra Help, as can the Social Security Administration. To apply for Extra Help, call SSA at 1-800-772-1213 (1-800-325-0778 TTY), or apply online at www.socialsecurity.gov. You may apply for Extra Help at any time of the year, and if you qualify, you will receive a Special Enrollment Period for selecting a Medicare Part D drug plan, and you may change your Part D plan at any time of the year. Individuals with Extra Help will not be subject to a late enrollment penalty in Part D.

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

CALL 311 AND ASK FOR HIICAP

Extra Help with Drug Plan Costs for People with Limited Incomes

The Social Security Administration (SSA), through which people sign up for Medicare Parts A and B, subsidizes the cost of a Part D plan for Medicare beneficiaries with lower incomes and limited resources. The subsidy is paid directly to the Part D plan. The program is called the Low-Income Subsidy Program (LIS), also known as Extra Help.

Full Extra Help is for beneficiaries with monthly incomes up to 135% of the Federal Poverty Level, $1,386 for an individual/$1,872 for couples in 2018 (estimated to be $1,405 individual/$1,902 couples in 2019), and resources up to $9,230 for individual/$14,600 for couples in 2019. These resource amounts include an additional $1,500 for individuals and $3,000 for couples for funeral or burial expenses.

Benefits of Full Extra Help:
- No monthly premium for a Part D plan, as long as the plan selected is a “benchmark” plan, a Basic plan that has a monthly premium that is fully subsidized by Extra Help (monthly premium up to $39.33 in 2019).
- No deductible.
- Reduced co-pays, depending on income - beneficiaries with incomes up to 100% of the Federal Poverty Level will have co-pays of $1.25 for generic and $3.80 for brand name prescriptions. All others with full Extra Help will have co-pays limited to $3.40 for generic and $8.50 for brand name prescriptions.

Partial Extra Help is for beneficiaries with monthly incomes up to 150% of the Federal Poverty Level, $1,538 for an individual/$2,078 for couples in 2018 (estimated to be $1,561 individual/$2,113 couples in 2019), and resources up to $14,390 for an individual/$28,720 for couples in 2019. These resource amounts include an additional $1,500 for individuals and $3,000 for couples for funeral or burial expenses.

Benefits of Partial Extra Help:
- Monthly plan premium on a sliding scale based on income.
- Deductible reduced to not more than $85.
- Reduced co-pays – pay the lower of 15% of drug costs or the plan’s cost-sharing.

HIICAP counselors can help screen for eligibility for Extra Help, as can the Social Security Administration. To apply for Extra Help, call SSA at 1-800-772-1213 (1-800-325-0778 TTY), or apply online at www.socialsecurity.gov. You may apply for Extra Help at any time of the year, and if you qualify, you will receive a Special Enrollment Period for selecting a Medicare Part D drug plan, and you may change your Part D plan at any time of the year. Individuals with Extra Help will not be subject to a late enrollment penalty in Part D.

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

CALL 311 AND ASK FOR HIICAP
NEW YORK STATE EPIC PROGRAM
(Elderly Pharmaceutical Insurance Coverage)

The Elderly Pharmaceutical Insurance Coverage program (EPIC) is New York State’s prescription drug insurance program for New York State’s senior citizens. If you are 65 years old or over, live in New York State, and have an income of up to $75,000 for singles/$100,000 for married couples, you may be eligible for EPIC. EPIC enrollees may purchase prescriptions at 4,500 participating pharmacies across New York.

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

EPIC members should present their Part D card and their EPIC card at the pharmacy each time they fill a prescription. After meeting any Part D deductible, EPIC is secondary coverage. EPIC also covers approved Part D excluded drugs, including prescription vitamins and cough and cold medicines. Members pay a reduced price for prescriptions depending on the cost of the medication under their Part D plan. For example: for a prescription costing between $15 and $35, they pay $7. The highest EPIC co-pay is $20 for a 30-day prescription, regardless of the price of the prescription under the Part D plan.

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

EPIC’s Fee Plan is for individuals with annual incomes up to $20,000 and married couples with incomes up to $26,000. To participate in the Fee Plan, participants pay the annual fee associated with their income. After paying the fee, participants pay the EPIC co-pay for their medications. Fees are based on the previous year’s annual income and are paid quarterly. For example: a single person with an income of $16,000 would be responsible for an annual fee of $110. A couple with an income of $24,000 would pay $260 per person to participate in EPIC’s Fee Plan.

EPIC pays the Part D monthly premium for Fee Plan members, up to $39.33 per month in 2019. In addition, EPIC members with full Extra Help (see page 34) will have their EPIC fees waived.

CALL 311 AND ASK FOR HIICAP
35

紐約州老人藥品保險 (EPIC) 計畫
(老人藥品保險)

老人藥品保險計畫 (EPIC) 是紐約州針對老人實施的處方藥保險計畫。凡是年滿 65 歲以上，居住在紐約州，單身者收入在 $75,000 以下／已婚夫妻收入在 $100,000 以下，就有資格申請 EPIC。加入 EPIC 可以在紐約 4,500 家加盟藥房購買處方藥。

EPIC 可作為聯邦醫療保險 D 部分的副保險，以降低藥物費用。您必須參加 D 部分保險 (PDP 或 MA-PD) 以擁有 EPIC，但是若您尚未參加 D 部分而登記加入 EPIC，您可以隨時選擇 D 部分計畫，擁有額外醫療補助的個人無資格參加 EPIC (參加醫療補助抵降保費計畫的個人仍有資格參加 EPIC)。

在藥房按配方取藥時，EPIC 會員應該出示其 D 部分卡及其 EPIC 卡。在滿足任何 D 部分自付額之後，EPIC 是副保險，EPIC 也承保核准的 D 部分排除藥物，包括處方維生素和咳嗽與感冒藥。根據 D 部分計畫，會員自付的處方藥費用較低，降低藥品成本而定。例如：處方費用介於 $15 和 $35 之間，他們支付 $7，最高 EPIC 共付額為 $20（適用於 30 天處方藥），無論根據 D 部分計畫的處方價格為何。

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

EPIC 的年費計畫是針對個人年收入在 $20,000 以下和已婚夫婦年收入在 $26,000 以下者。欲參加年費計畫，參加者須具備收入繳交年費，繳交年費之後，參加者須為他們的藥品支付 EPIC 共付額。年費是根據前一年的年收入而定，按季繳納。例如：收入為 $16,000 的單身人士須繳交 $110 的年費，收入為 $24,000 的夫婦則須每人支付 $260 以參加 EPIC 的年費計畫。

EPIC 為年費計畫會員支付 D 部分月保費，2019 年每月最高至 $39.33，此外，取得額外補助（請見第 34 頁）的 EPIC 會員將免繳 EPIC 年費。

請致電 311 諮詢 HIICAP
EPIC’s Deductible Plan is for individuals with annual incomes between $20,001 and $75,000, and married couples with incomes between $26,001 and $100,000. To participate in the Deductible Plan, participants pay for their prescriptions until they meet their EPIC deductible amount, which is based on the previous year’s income. After meeting the deductible, participants pay only the EPIC co-pay. For example, a single person with an income of $23,000 must meet an annual deductible of $700. For a married couple with an income of $29,000, each person must meet an annual deductible of $700. There is no fee to join the deductible plan.

EPIC pays the Part D monthly premium (up to $39.33 per month in 2019) for Deductible Plan members with incomes up to $23,000 single/$29,000 married. Deductible Plan members with higher incomes must pay their own Part D premiums, but their EPIC deductible will be lowered by the annual cost of a basic Part D plan (approximately $472 in 2019).

After a Deductible Plan member reaches his/her deductible, all that they will need to pay is the EPIC co-payment for covered drugs. Drug costs incurred in the Part D deductible phase cannot be applied to the EPIC deductible.

*TIPS*

- EPIC members without Extra Help may want to look into a Part D plan without a deductible; EPIC does not cover prescription medications purchased during a Part D plan’s deductible period.
- EPIC enrollment and EPIC copays are not reflected in the www.medicare.gov Planfinder tool.

How does EPIC work with Medicare Part D?

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

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

Part D coverage is primary and EPIC coverage is always secondary. The enrollee pays the EPIC co-pay based on the amount remaining after the Part D plan pays, thus reducing the enrollee’s costs. For example, if you are responsible for paying a $20 co-pay for a drug using your Part D coverage and also have EPIC, you would pay the EPIC co-pay on a $20 drug, which is $7. In addition, EPIC will cover you after you have met any Part D deductible, including during the initial coverage level, the “donut hole” (the Part D coverage gap), and during catastrophic coverage, as long as the drugs are first covered by your Part D plan. Approved Part D excluded drugs can be covered by EPIC first for those enrolled in Part D drug plans. EPIC will be a secondary payer for Part D plan members who use EPIC participating mail order pharmacies, even if that mail order pharmacy is outside of NY State. (EPIC will not pay the out-of-state pharmacy for a drug not covered by the Part D plan.)

CALL 311 AND ASK FOR HIICAP

EPIC’s Deductible Plan is for individuals with annual incomes between $20,001 and $75,000, and married couples with incomes between $26,001 and $100,000. To participate in the Deductible Plan, participants pay for their prescriptions until they meet their EPIC deductible amount, which is based on the previous year’s income. After meeting the deductible, participants pay only the EPIC co-pay. For example, a single person with an income of $23,000 must meet an annual deductible of $700. For a married couple with an income of $29,000, each person must meet an annual deductible of $700. There is no fee to join the deductible plan.

EPIC pays the Part D monthly premium (up to $39.33 per month in 2019) for Deductible Plan members with incomes up to $23,000 single/$29,000 married. Deductible Plan members with higher incomes must pay their own Part D premiums, but their EPIC deductible will be lowered by the annual cost of a basic Part D plan (approximately $472 in 2019).

After a Deductible Plan member reaches his/her deductible, all that they will need to pay is the EPIC co-payment for covered drugs. Drug costs incurred in the Part D deductible phase cannot be applied to the EPIC deductible.

*TIPS*

- EPIC members without Extra Help may want to look into a Part D plan without a deductible; EPIC does not cover prescription medications purchased during a Part D plan’s deductible period.
- EPIC enrollment and EPIC copays are not reflected in the www.medicare.gov Planfinder tool.

How does EPIC work with Medicare Part D?

New York law requires EPIC members to also be enrolled in a Medicare Part D plan (see Medicare Part D, page 30), if someone cannot enroll in Part D for whatever reason, they are not eligible for EPIC.

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

Part D coverage is primary and EPIC coverage is always secondary. The enrollee pays the EPIC co-pay based on the amount remaining after the Part D plan pays, thus reducing the enrollee’s costs. For example, if you are responsible for paying a $20 co-pay for a drug using your Part D coverage and also have EPIC, you would pay the EPIC co-pay on a $20 drug, which is $7. In addition, EPIC will cover you after you have met any Part D deductible, including during the initial coverage level, the “donut hole” (the Part D coverage gap), and during catastrophic coverage, as long as the drugs are first covered by your Part D plan. Approved Part D excluded drugs can be covered by EPIC first for those enrolled in Part D drug plans. EPIC will be a secondary payer for Part D plan members who use EPIC participating mail order pharmacies, even if that mail order pharmacy is outside of NY State. (EPIC will not pay the out-of-state pharmacy for a drug not covered by the Part D plan.)

CALL 311 AND ASK FOR HIICAP

EPIC’s Deductible Plan is for individuals with annual incomes between $20,001 and $75,000, and married couples with incomes between $26,001 and $100,000. To participate in the Deductible Plan, participants pay for their prescriptions until they meet their EPIC deductible amount, which is based on the previous year’s income. After meeting the deductible, participants pay only the EPIC co-pay. For example, a single person with an income of $23,000 must meet an annual deductible of $700. For a married couple with an income of $29,000, each person must meet an annual deductible of $700. There is no fee to join the deductible plan.

EPIC pays the Part D monthly premium (up to $39.33 per month in 2019) for Deductible Plan members with incomes up to $23,000 single/$29,000 married. Deductible Plan members with higher incomes must pay their own Part D premiums, but their EPIC deductible will be lowered by the annual cost of a basic Part D plan (approximately $472 in 2019).

After a Deductible Plan member reaches his/her deductible, all that they will need to pay is the EPIC co-payment for covered drugs. Drug costs incurred in the Part D deductible phase cannot be applied to the EPIC deductible.

*TIPS*

- EPIC members without Extra Help may want to look into a Part D plan without a deductible; EPIC does not cover prescription medications purchased during a Part D plan’s deductible period.
- EPIC enrollment and EPIC copays are not reflected in the www.medicare.gov Planfinder tool.

How does EPIC work with Medicare Part D?

New York law requires EPIC members to also be enrolled in a Medicare Part D plan (see Medicare Part D, page 30), if someone cannot enroll in Part D for whatever reason, they are not eligible for EPIC.

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

Part D coverage is primary and EPIC coverage is always secondary. The enrollee pays the EPIC co-pay based on the amount remaining after the Part D plan pays, thus reducing the enrollee’s costs. For example, if you are responsible for paying a $20 co-pay for a drug using your Part D coverage and also have EPIC, you would pay the EPIC co-pay on a $20 drug, which is $7. In addition, EPIC will cover you after you have met any Part D deductible, including during the initial coverage level, the “donut hole” (the Part D coverage gap), and during catastrophic coverage, as long as the drugs are first covered by your Part D plan. Approved Part D excluded drugs can be covered by EPIC first for those enrolled in Part D drug plans. EPIC will be a secondary payer for Part D plan members who use EPIC participating mail order pharmacies, even if that mail order pharmacy is outside of NY State. (EPIC will not pay the out-of-state pharmacy for a drug not covered by the Part D plan.)

CALL 311 AND ASK FOR HIICAP
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 stand-alone Part D plan with Original Medicare) one additional time each year.

EPIC and Extra Help
EPIC members who appear to be income eligible for Extra Help for paying for Medicare Part D costs (see page 34) are required to complete an additional form called Request for Additional Information (RFAI) so that EPIC can apply to the Social Security Administration for Extra Help on their behalf. The application for Extra Help will also be submitted to New York State's Medicaid program to assess eligibility for a Medicare Savings Program (see page 39) to help pay for the Medicare Part B premium.

<table>
<thead>
<tr>
<th>Co-payments for Medicare Part D and EPIC covered or approved Part D excluded drugs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Cost (after submitting to Medicare Part D plan)</td>
<td>EPIC Co-Payment</td>
</tr>
<tr>
<td>Up to $15</td>
<td>$3</td>
</tr>
<tr>
<td>$15.01 to $35</td>
<td>$7</td>
</tr>
<tr>
<td>$35.01 to $55</td>
<td>$15</td>
</tr>
<tr>
<td>Over $55</td>
<td>$20</td>
</tr>
</tbody>
</table>

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

Applying for EPIC
- You can call EPIC at 1-800-332-3742 (TTY: 1-800-290-9138) to request an application.
- Visit https://www.health.ny.gov/health_care/epic/ for more information on EPIC and to download and print an application. You can also submit an online request for EPIC to mail you an application.
- Fax the completed EPIC application to 518-452-3576, or mail the completed application to EPIC, P.O. Box 15018, Albany, NY 12212-5018.

EPIC 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 stand-alone Part D plan with Original Medicare) one additional time each year.

EPIC and Extra Help
EPIC members who appear to be income eligible for Extra Help for paying for Medicare Part D costs (see page 34) are required to complete an additional form called Request for Additional Information (RFAI) so that EPIC can apply to the Social Security Administration for Extra Help on their behalf. The application for Extra Help will also be submitted to New York State's Medicaid program to assess eligibility for a Medicare Savings Program (see page 39) to help pay for the Medicare Part B premium.

<table>
<thead>
<tr>
<th>Co-payments for Medicare Part D and EPIC covered or approved Part D excluded drugs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Cost (after submitting to Medicare Part D plan)</td>
<td>EPIC Co-Payment</td>
</tr>
<tr>
<td>Up to $15</td>
<td>$3</td>
</tr>
<tr>
<td>$15.01 to $35</td>
<td>$7</td>
</tr>
<tr>
<td>$35.01 to $55</td>
<td>$15</td>
</tr>
<tr>
<td>Over $55</td>
<td>$20</td>
</tr>
</tbody>
</table>

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

Applying for EPIC
- You can call EPIC at 1-800-332-3742 (TTY: 1-800-290-9138) to request an application.
- Visit https://www.health.ny.gov/health_care/epic/ for more information on EPIC and to download and print an application. You can also submit an online request for EPIC to mail you an application.
- Fax the completed EPIC application to 518-452-3576, or mail the completed application to EPIC, P.O. Box 15018, Albany, NY 12212-5018.

EPIC 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 stand-alone Part D plan with Original Medicare) one additional time each year.

EPIC and Extra Help
EPIC members who appear to be income eligible for Extra Help for paying for Medicare Part D costs (see page 34) are required to complete an additional form called Request for Additional Information (RFAI) so that EPIC can apply to the Social Security Administration for Extra Help on their behalf. The application for Extra Help will also be submitted to New York State's Medicaid program to assess eligibility for a Medicare Savings Program (see page 39) to help pay for the Medicare Part B premium.

<table>
<thead>
<tr>
<th>Co-payments for Medicare Part D and EPIC covered or approved Part D excluded drugs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Cost (after submitting to Medicare Part D plan)</td>
<td>EPIC Co-Payment</td>
</tr>
<tr>
<td>Up to $15</td>
<td>$3</td>
</tr>
<tr>
<td>$15.01 to $35</td>
<td>$7</td>
</tr>
<tr>
<td>$35.01 to $55</td>
<td>$15</td>
</tr>
<tr>
<td>Over $55</td>
<td>$20</td>
</tr>
</tbody>
</table>

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

Applying for EPIC
- You can call EPIC at 1-800-332-3742 (TTY: 1-800-290-9138) to request an application.
- Visit https://www.health.ny.gov/health_care/epic/ for more information on EPIC and to download and print an application. You can also submit an online request for EPIC to mail you an application.
- Fax the completed EPIC application to 518-452-3576, or mail the completed application to EPIC, P.O. Box 15018, Albany, NY 12212-5018.

CALL 311 AND ASK FOR HIICAP

EPIC and Extra Help
EPIC members who appear to be income eligible for Extra Help for paying for Medicare Part D costs (see page 34) are required to complete an additional form called Request for Additional Information (RFAI) so that EPIC can apply to the Social Security Administration for Extra Help on their behalf. The application for Extra Help will also be submitted to New York State's Medicaid program to assess eligibility for a Medicare Savings Program (see page 39) to help pay for the Medicare Part B premium.

<table>
<thead>
<tr>
<th>Co-payments for Medicare Part D and EPIC covered or approved Part D excluded drugs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Cost (after submitting to Medicare Part D plan)</td>
<td>EPIC Co-Payment</td>
</tr>
<tr>
<td>Up to $15</td>
<td>$3</td>
</tr>
<tr>
<td>$15.01 to $35</td>
<td>$7</td>
</tr>
<tr>
<td>$35.01 to $55</td>
<td>$15</td>
</tr>
<tr>
<td>Over $55</td>
<td>$20</td>
</tr>
</tbody>
</table>

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

Applying for EPIC
- You can call EPIC at 1-800-332-3742 (TTY: 1-800-290-9138) to request an application.
- Visit https://www.health.ny.gov/health_care/epic/ for more information on EPIC and to download and print an application. You can also submit an online request for EPIC to mail you an application.
- Fax the completed EPIC application to 518-452-3576, or mail the completed application to EPIC, P.O. Box 15018, Albany, NY 12212-5018.
BigAppleRx
PRESCRIPTION DRUG DISCOUNT CARD

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

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

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

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

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

By visiting www.BigAppleRx.com or calling 311 or 1-888-454-5602, you can:
• Get more information on the BigAppleRx card.
• Get a card.
• Find a participating local pharmacy.
• Find out how much a prescription would cost using the card.

CALL 311 AND ASK FOR HIICAP
MEDICARE SAVINGS PROGRAMS

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

Below is information on the Medicare Savings Programs, followed by income limits for each of the programs, and how to apply.

- **Qualified Medicare Beneficiary Program (QMB):** This program can pay for the Medicare Part A and/or Part B premium, as well as the coinsurance and deductibles for Parts A and B. An individual can be eligible for QMB only, or for QMB as well as Medicaid. Individuals with QMB should see providers who accept both Medicare and Medicaid if they want full Medical coverage with no out-of-pocket costs.
  - NEW: QMB status is now noted on the Medicare Summary Notice, making it clear that the QMB beneficiary is not responsible for any Medicare cost-sharing.
- **Specified Low Income Medicare Beneficiary Program (SLMB):** This program pays for the Medicare Part B premium. Individuals can be eligible for SLMB only, or for SLMB and Medicaid (with a spenddown). The applicant must have Medicare Part A in order to be eligible for SLMB.
- **Qualified Individual (QI):** This program pays for the Medicare Part B premium. Individuals cannot be eligible for both QI and Medicaid. The applicant must have Medicare Part A to be eligible for QI.
- **Qualified Working and Disabled Individual (QWDI):** This program pays for the Medicare Part A premium only, not Part B. The applicant must be a disabled worker under age 65 who lost Part A benefits because of return to work.

<table>
<thead>
<tr>
<th>2018 MSP Monthly Income and Resource Limits (after any deductions/exclusions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single</strong></td>
</tr>
<tr>
<td>Income</td>
</tr>
<tr>
<td>QMB: 100% FPL</td>
</tr>
<tr>
<td>SLMB: 120% FPL</td>
</tr>
<tr>
<td>QI: 135% FPL</td>
</tr>
</tbody>
</table>

**2019 ESTIMATE**

<table>
<thead>
<tr>
<th>2019 MSP Monthly Income and Resource Limits (after any deductions/exclusions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single</strong></td>
</tr>
<tr>
<td>Income</td>
</tr>
<tr>
<td>QMB: 100% FPL</td>
</tr>
<tr>
<td>SLMB: 120% FPL</td>
</tr>
<tr>
<td>QI: 135% FPL</td>
</tr>
</tbody>
</table>

**聯邦醫療保費免保費計劃**

聯邦醫療保費免保費計劃 (MSP) 可以幫助符合資格的個人支付他們的聯邦醫療保費保費及其他與聯邦醫療保費相關的費用。聯邦醫療保費免保費計劃是由位於紐約市的人力資源管理局 (HRA) 管理。

以下為聯邦醫療保費免保費計劃的資訊，之後則是每項計劃的收入限制及如何適用。

- **合格的聯邦醫療保費受益人計劃 (QMB):** 本計劃可支付聯邦醫療保費 A 部分和/或 B 部分保費，以及 A 部分和 B 部分的共保額和自付額。個人可能只符合 QMB 的資格，也可能同時符合 QMB 和醫療補助的資格。擁有 QMB 者若想享有全額醫療補助而無須負擔自付額，就應該去看是否接受聯邦醫療保費和醫療補助的醫療業者。
  - 新項：QMB 狀態現在出現在聯邦醫療保費概要通知之中，明確顯示 QMB 受益人並不負責任何聯邦醫療保費費用分擔。
- **特定低收入聯邦醫療保費受益人計劃 (SLMB):** 本計劃支付聯邦醫療保費 B 部分保費，個人可能只符合 SLMB 的資格，也可能同時符合 SLMB 和醫療補助 (豁免保費計劃) 的資格。申請人必須擁有聯邦醫療保費 A 部分方能有資格申請 SLMB。
- **合格個人計劃 (QI):** 本計劃支付聯邦醫療保費 B 部分保費，個人可能同時符合 QI 和醫療補助的資格。申請人必須擁有聯邦醫療保費 A 部分方能有資格申請 QI。
- **合格在職殘障人士計劃 (QWDI):** 本計劃只支付聯邦醫療保費 A 部分保費，不包括 B 部分保費。申請人必須是 65 歲以下的殘障勞工，因恢復工作而喪失了 A 部分的保險資格。

<table>
<thead>
<tr>
<th>2018 年聯邦醫療保費免保費計劃收入及資產上限 (減去任何扣除額/抵免之後)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>單身</strong></td>
</tr>
<tr>
<td>收入</td>
</tr>
<tr>
<td>QMB：100% 聯邦貧窮線</td>
</tr>
<tr>
<td>SLMB：120% 聯邦貧窮線</td>
</tr>
<tr>
<td>QI：135% 聯邦貧窮線</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2019 年預估值</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>聯邦醫療保費免保費計劃收入及資產上限 (減去任何扣除額/抵免之後)</strong></td>
</tr>
<tr>
<td><strong>單身</strong></td>
</tr>
<tr>
<td>收入</td>
</tr>
<tr>
<td>QMB：100% 聯邦貧窮線</td>
</tr>
<tr>
<td>SLMB：120% 聯邦貧窮線</td>
</tr>
<tr>
<td>QI：135% 聯邦貧窮線</td>
</tr>
</tbody>
</table>
Applying for a Medicare Savings Program

• One can apply through a Deputized Agent, at the local Medicaid office, or by mail.
  o A Deputized Agent will assist you with completing the application and collecting the necessary supporting documents. To make an appointment with a deputized HIICAP counselor, call 311 and ask for HIICAP. You can also reach out to the Medicare Rights Center at 1-800-333-4114.
  o Reach out to a Facilitated Enroller. Visit https://www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf or call 347-396-4705 to locate a center near your home where you can get assistance completing the application.
  o Mail the completed application and copies of supporting documents to: Medical Assistance Program; MSP-CREP, 5th Floor; P.O. Box 24330; Brooklyn, NY 11202-9801.

What application do I use?

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

Medicare Savings Program advocacy tips:

• Individuals in an MSP are automatically eligible for full Extra Help to lower their Medicare Part D drug costs (see page 34).
• If you apply for Extra Help at a Social Security Administration you can be considered as applying for QMB, SLMB or QI. SSA will forward your information to New York State to be considered for MSP eligibility.
• You do not need to go to a Medicaid office to apply for an MSP.
• Even if you are still working you may qualify for a Medicare Savings Program.

What counts as income when applying for an MSP?

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

Note: The MSP program requires that you be collecting any Social Security benefits for which you are eligible, unless you are working full time.

申請聯邦醫療保險免保費計畫

• 申請人可透過郵寄申請。在當地醫療補助辦事處，或透過郵件申請。
  o 委員會隨後將協助您填妥申請表並收集所需之必要文件。欲查詢 HIICAP 委員會，請致電 311 洽詢 HIICAP。您亦可致電 1-800-333-4114 洽詢聯邦醫療保險權益中心。
  o 請將填妥的申請表及所需文件的副本一併寄至：Medical Assistance Program; MSP-CREP, 5th Floor; P.O.Box 24330; Brooklyn, NY 11202-9801。

使用哪種申請表？

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

聯邦醫療保險免保費計畫申請要預備:

• 擁有聯邦醫療保險免保費計畫者，自動符合領取額外補助的資格，以降低聯邦醫療保險部分藥品費用（請見第 34 頁）。
• 若您在社會安全局申請額外補助，您可被視作申請 QMB、SLMB 或 QI。社會安全局將根據您的申請，以考慮是否符合聯邦醫療保險免保費計畫的資格條件。
• 您無須至醫療補助辦事處去申請聯邦醫療保險免保費計畫。
• 即便您仍在工作，您也可能符合聯邦醫療保險免保費計畫的資格。

申請聯邦醫療保險免保費計畫（MSP）時，哪些可視為收入？

• 收入包括來自僱主或自僱發放的薪資。其中包括每月領取的資金，如社會保險、養老金、退伍軍人福利、失業保險等。
• 某些收入將不被計入，當決定聯邦醫療保險免保費計畫（MSP）資格時，被計入的金額會被減少，其包括已支付的健康管理費用，例如：Medigap 保費、長期護理保費、退休人士健康保險費及牙科保險。

註：除非您從事全職工作，否則該 MSP 計劃要求您必須領取任何有資格獲得的社會安全福利。
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.
• 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.

CALL 311 AND ASK FOR HIICAP

41
Be alert to:

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

How to report Medicare fraud

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

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

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

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

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

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

IDENTITY THEFT

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

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

CALL 311 AND ASK FOR HIICAP
MEDICAID ELIGIBILITY FOR 65+, BLIND OR DISABLED

Medicaid is a joint federal, state and city government health insurance program for low-income individuals. Medicaid is a “means tested” program requiring applicants to prove financial need in order to be eligible. Once an individual is determined to be Medicaid eligible, a permanent plastic Medicaid card is issued and is valid as long as he or she remains eligible. In addition to financial guidelines, Medicaid requires that you be a U.S. citizen or qualified alien. In order to apply for Medicaid in NYC you must reside in NYC.

MEDICAID COVERED SERVICES

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

Where and how you apply for Medicaid depends on your “category”: those 65+, blind or disabled apply through the NYC Human Resources Administration; those under 65 and not blind or disabled apply through the NY State of Health. This section discusses how individuals 65+, blind or disabled apply for Medicaid. See page 51 for information on Medicaid for those who are under 65 and not blind or disabled.

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

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

COMmUNITY MEDICAID has a maximum monthly countable income of $859 for single individuals/$1,267 for married couples, and an asset limit of $15,450 (plus $1,500 in a burial fund) for single individuals/ $22,800 (plus $3,000 in burial funds) for married couples in 2019.

CALL 311 AND ASK FOR HIICAP

针对 65 岁以上老人、盲人或残障人士的医疗援助资格

医疗援助是联邦、州及市政府共同为低收入人士而开办的健康保险计划。医疗援助是需

「经过经济情况调查」的计划，申请人必须证明财务需要才能符合条件。一旦申请人被确

定符合医疗援助资格，将给予一张永久性的塑胶医疗援助卡。只要当事人仍符合资格

就一直有效，除了财务准则以外，必须是美国公民或符合资格的外籍人士才能申请医疗

援助，您必须居住在纽约市，才能在纽约市申请医疗援助。

医疗援助包括的项目

- 急诊及住院服务
- 预防性保健服务
- 借助设备服务
- 案例管理服务
- 物理治疗
- 言语及听力复健
- 结核病 (TB) 相关服务
- 心理健康服务
- 私人看护
- 助行器
- 診断服务
- 职能服务
- 遊览服务
- 疗愈服务
- 安寧服務
- 眼镜及验光服务
- 牙科服务及假牙
- 眼镜辅助
- 交通
- 家庭医疗護理

您可以去哪裡及如何申请医疗援助视您的「类别」而定：65 岁以上老人、盲人或残障人士

可透过纽约州市人力资源管理局申请；未满 65 岁及非盲人或非残障人士则可透过纽约州卫

生署申请。本节讨论身份为 65 岁以上，眼盲或残障的人士如何申请医疗援助，请参看第

51 页。了解 65 岁且未有失明或失聪的人士的医疗援助相关资讯。

65 岁以上，眼盲或残障的人士可能在不同的方面符合医疗援助资格，这视他们正在申请

的服务而定。

- 社区医疗援助指的是人们使用的医疗援助，其時他們居住在自己家裡並且將醫療補

助作为健康保险保障。

- 機構醫療援助指的是醫療援助，提供全系列健康醫療保險並且支付與職護理院全部

時間護理 (這與臨時性、而且為聯邦醫療保險 A 部分所承保的專業護理設施的護理

不同)。

社区医疗援助 2019 年规定：月度可计收入上限（单身人士为 $859/已婚夫妻为 $1,267)

以及资产限制（单身人士为 $15,450，外加在丧葬基金中的 $1,500/已婚夫妻为 $22,800，

外在外丧葬基金中的 $3,000)。
Medicaid counts income from all sources, including wages, and Social Security and pension payments. There are certain allowable income deductions, so even if your income is over these amounts, you are encouraged to apply. Additionally, if your income is over these amounts, you may be eligible to participate in Medicaid’s Excess Income Program (Medicaid Spenddown). With the Spenddown Program, you spend down your “excess amount,” the amount by which you are over Medicaid’s income limit, on health expenses and then you have full Medicaid coverage for the remainder of the month.

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

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

If your income and/or assets are over Medicaid’s allowed amounts, you may want to consider applying for a Medicare Savings Program to help pay the Medicare premiums and other costs associated with Medicare (see page 39 for more information).

The Medicaid application
Applicants complete the Access NY Health Care application, form DOH 4220, as well as Supplement A. You can access the applications and instructions, in both English and Spanish, at https://www.health.ny.gov/health_care/medicaid/#apply.

Where do I submit the application?
You have a choice of where and how to submit your Medicaid application:
• Contact a facilitated enroller near you for assistance. HIICAP counselors can direct you to an agency in your borough or you can visit http://www1.nyc.gov/assets/ochia/downloads/pdf/facilitated-enrollers.pdf for a listing of enrollers.
• Go to your local Medicaid office—you can get help with completing the application in person at the office or drop off a completed application. See page 67 for a list of Medicaid offices, or call 311 and ask for the Human Resources Administration, or visit http://www1.nyc.gov/site/hra/locations/medicaid-locations.page.
• Submit an application by mail. Mail the completed application along with supporting documents to:
  Initial Eligibility Unit
  HRA/Medicaid Assistance Program
  P.O. Box 2798
  New York, NY 10117-2273

CALL 311 AND ASK FOR HIICAP
Recertification

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

Eliminating the “Spendingdown” 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 “spendingdown” moneys to Medicaid. The pooled-income trust fund, managed by a nonprofit agency, receives the individual’s monthly surplus income and redistributes it on behalf of that individual as directed by the individual or their legal representative. Please speak to an eldercare lawyer or a knowledgeable geriatric care manager for further information regarding estate planning and the supplemental needs trust.

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

How does Medicaid work with Medicare?

It is possible to have both Medicare and Medicaid. People with both Medicare and Medicaid are known as “dual eligibles.” Medicare is primary coverage and Medicaid secondary. In addition to paying for Medicare’s cost-sharing requirements, such as the Part A deductible and Part B deductible and 20% co-insurance, Medicaid in New York also offers benefits, such as home health care, and dental and vision services, which are not covered under the Medicare program.

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

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

How does Medicaid interact with Medicare Part D?

Dual eligibles are automatically enrolled in full Extra Help (see page 34) and will be automatically enrolled in a Part D plan if they do not sign up for one on their own. As long as a dual eligible is enrolled in a Part D plan that is classified as a “benchmark” plan, he/she will pay no premium for Part D coverage, and only pay modest co-pays for their prescriptions. Dual eligibles with incomes under 100% of the Federal Poverty Level (FPL) will have co-pays of $1.25 for generic/$3.80 for brand name prescriptions in 2019. Those with incomes over 100% FPL will have co-pays of $3.35 for generic/$8.50 for brand name prescriptions.

CALL 311 AND ASK FOR HIICAP

45

医療補助與聯邦醫療保險如何發揮作用？

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

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

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

醫療補助與聯邦醫療保險 D 部分如何交互運作？

雙重資格者自動加入全額額外補助 (請參閱第 34 頁)，而且將自動加入 D 部分計畫，若他們沒有主動登記加入一項計畫，只要雙重資格者登記參加被分類為「基準」計畫的 D 部分計畫，其將不支付 D 部分保費的保費，而且還支付其處方的共付額。2019 年，具雙重資格者的收入若在聯邦貧窮線 (FPL) 的 100% 之下，所負擔的共付額為非原廠等同藥 $1.25 原廠品牌藥 $3.80，收入超過 100% 聯邦貧窮線者的共付額為非原廠等同藥 $3.35/原廠品牌藥 $8.50。

重新認證

醫藥補助領得為期 12 個月的授權，而他們長期的承保範圍中，HRA 應該重新發一個必須填寫完整的重新認證包，以便重新核保資格。

消費針對醫療補助申請者的「抵降」

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

如需詳細資訊，請聯絡 Evelyn Frank 法律資源計畫紐約法律援助組：212-613-7310，或寄送電子郵件至 EFLRP@NYLAG.org。
Certain drugs, by law, are not covered by Part D, such as over-the-counter medications and vitamins. These will continue to be covered by Medicaid with a prescription.

Because dual eligibles automatically receive Extra Help, they can change how they get their Part D benefits 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, and then again during the Annual Election Period (October 15 – December 7), with the change effective January 1. (Note: Individuals with Medicaid-only do not enroll in a Medicare Part D plan.)

Mandatory Medicaid Managed Long Term Care:

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

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

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

2. If you are required to enroll in a managed long-term care plan, you will receive a packet in the mail from New York Medicaid Choice, telling you about your choices and how to enroll. You will have 60 days to enroll in a plan. If you don’t select a plan for yourself, you will be automatically enrolled in a Managed Long Term Care plan (see first bullet below).

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

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

- **Managed Long Term Care (MLTC):** MLTC plans provide long term care services, as well as a few other services, such as home modifications, non-emergency medical transportation, podiatry, audiology, dental and optometry. MLTC enrollees will continue to use their current plan (i.e. your Medicare card, your Medicaid card, or your Medicare Advantage card) for all other Medicare and Medicaid services. Individuals who do not enroll in a managed long-term care plan on their own will be automatically enrolled into an MLTC plan. This is the most flexible of the managed long-term care plan options, as you can maintain you current Medicare and Medicaid provider arrangements.

CALL 311 AND ASK FOR HIICAP

46
• Medicaid Advantage Plus (MAPlus): MAPlus plans provide ALL Medicaid AND Medicare services, including long-term care services. Members receive all Medicaid and Medicare services from the same plan and must use in-network providers.

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

• Fully Integrated Dual Advantage (FIDA): FIDA plans provide all Medicare and Medicaid services, including home care services and Medicare Part D drug coverage, in a single plan. There are no copays or deductibles, including for prescription drugs, though prescription drugs need to be on the plan’s formulary. In addition, FIDA enrollees will not have to pay the Part B premium, regardless of whether they are enrolled in a Medicare Savings Program (see page 39).

For further information on the types of managed long-term care plans, visit:
- MLTC, MAP+ and PACE: https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_guide_e.pdf
- FIDA: https://www.health.ny.gov/health_care/medicaid/redesign/fida/

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

How will managed long term care work with a Medicaid Spenddown?
Many people have Medicaid with a spenddown to help them pay for Medicaid-covered home care services. These individuals will now pay their Medicaid spenddown to the health plan. If a member does not pay the spenddown, the plan can disenroll the member.

• Medicaid Advantage Plus (MAPlus): MAPlus plans provide ALL Medicaid AND Medicare services, including long-term care services. Members receive all Medicaid and Medicare services from the same plan and must use in-network providers.

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

• Fully Integrated Dual Advantage (FIDA): FIDA plans provide all Medicare and Medicaid services, including home care services and Medicare Part D drug coverage, in a single plan. There are no copays or deductibles, including for prescription drugs, though prescription drugs need to be on the plan’s formulary. In addition, FIDA enrollees will not have to pay the Part B premium, regardless of whether they are enrolled in a Medicare Savings Program (see page 39).

For further information on the types of managed long-term care plans, visit:
- MLTC, MAP+ and PACE: https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_guide_e.pdf
- FIDA: https://www.health.ny.gov/health_care/medicaid/redesign/fida/

若要進一步瞭解管理式長期護理計畫類型，請造訪：
- MLTC、MAP+ 和 PACE：https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_guide_e.pdf
- FIDA：https://www.health.ny.gov/health_care/medicaid/redesign/fida/

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

管理模式長期護理將如何與醫療補助抵銷辦作？
許多人士藉著醫療補助抵銷保費計畫，支付醫療補助保險的居家護理服務。該人士將需要在健康保險計畫中支付醫療補助抵銷保費計畫，若會員不支付抵銷保費計畫，該計畫可將該會員除名。
How do I select a plan?
1. Decide what type of plan would best suit your needs (MLTC, MAPlus, PACE or FIDA).
2. Ask your providers (home care agency, medical providers, etc.) what plans they participate in so that you can pick a plan that will allow you to continue seeing your providers. If you wish to enroll in a MAPlus, PACE or FIDA plan, you also need to get your Part D drug coverage through that plan; the Planfinder, at www.medicare.gov, should have the prescription drug information for these plans online.
3. To enroll in the plan, call NY Medicaid Choice at 1-888-401-6582. NY Medicaid Choice should also be able to help you select a plan.

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

What if I want to switch managed long term care plans?
You can switch plans at any time. New York Medicaid Choice (Maximus) handles enrollment for Medicaid managed long-term care and can be reached at 1-888-401-6582.
The change must be requested by the 19th of the month for the new plan to be effective the first of the following month.

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

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

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

CALL 311 AND ASK FOR HIICAP
Medicaid will impose a “transfer penalty” if any such transfers are found within the 5-year look-back period. The transfer penalty means that Medicaid will not pay for the nursing home stay for a period of time proportional to the amount of money transferred. In NYC in 2019, the total amount of money transferred will be divided by $12,419 to determine the number of months of the penalty period. For example, if an applicant was found to have transferred $124,190 to family members in the 5 years before the month of application, the penalty period would be 10 months long. That individual would have to find a way to private-pay for the nursing home stay for 10 months before Medicaid coverage would begin. There are certain exceptions to the transfer penalty; applicants should consult a lawyer for advice on these matters.

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

若在這個5年覈查期內發現任何類型轉帳，醫療補助將會施加「轉帳罰金」。轉帳罰金代表醫療補助將不支付護理院入住所轉帳金額成比例的時間。2019年紐約市的轉帳總金額將被除以$12,419，以判定罰金期的月數。例如，若申請者被發現在申請當月的前5年內曾將$124,190轉帳給家庭成員，這個罰期將會長10個月。該個人將不得不在醫療補助保險本將開始之前在護理院入住的10個月。轉帳罰金有某些例外情況；申請者應諮詢律師，尋求這些事宜的有關建議。

一旦其機構醫療補助申請已被接受，申請人將得到通知，他們必須在60天之內選擇一項管理式長期護理計畫，以便繼續接受機構醫療補助。若他們參加聯邦醫療保險，他們將必須選擇一項管理式長期護理計畫（MLTC，MAPlus，PACE或FIDA）。若他們希望住在同一家護理之家，他們必須選擇有和該機構簽約的計畫（除非他們選擇FIDA計畫，因為FIDA計畫必須涵蓋護理之家網以外的機構，若該院所為當事人在登記加入時的居住之處）。紐約醫療補助選擇（NY Medicaid Choice）能夠幫助個人選擇對其最佳的計畫。若他們未選擇計畫，他們將被自動分配一項與其護理院簽約的計畫。
The Health Insurance Exchange is an organized marketplace for purchasing health insurance. In New York State, the Exchange is known as New York State of Health: The Official Health Plan Marketplace. There are many health insurance options available through the Marketplace in New York City. Marketplace plans offer comprehensive health coverage, and have a cost sharing structure that can include premiums, deductibles, copayments, and maximum out-of-pocket costs.

All plans that offer coverage through the Marketplace are HMOs, the most restrictive form of managed care. In New York City, you must select a plan that serves your borough.

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

How to apply for coverage through the Marketplace:
- Receive free application assistance through a Navigator. Visit https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations for a listing of navigator.

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. Anyone who is a citizen or a legal permanent resident residing in New York can 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. You will get your Medicaid through the Marketplace.
- 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.
- Medicaid 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 explore supplemental coverage to help pay for what Medicare does not cover. See page 18 for information on Medigap insurance.
- You do not need to enroll in other health insurance if you have comprehensive health insurance coverage through TRICARE, the Veterans Health Program, a plan offered by an employer, insurance that you have bought on your own that is at least at the Bronze level (as determined by the Marketplace), or a grandfathered health plan that was in existence before the health reform law was enacted. If you verify.

MEDICAID FOR PEOPLE UNDER 65, NOT BLIND OR DISABLED

Pregnant women, children up to age 18, parents/caretaker relatives, and childless adults ages 19-64 are evaluated for Medicaid eligibility under MAGI (Modified Adjusted Gross Income) budgeting. Those with incomes up to 138% FPL, estimated at $1,436 for individuals/$1,944 for couples in 2019, may qualify for Medicaid. Children up to age 19 can qualify for Medicaid at higher income levels. There is no asset limit for these populations. Individuals will receive their Medicaid benefits through a managed care plan (HMO), which should be selected at the time of application.

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

Recertifying for Medicaid

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

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. Exception: Parents/Caretaker relatives of minor children are allowed to maintain Medicaid through the NY State of Health and also have Medicare.

CALL 311 AND ASK FOR HIICAP

51

请教電 311洽詢 HIICAP

51
Medicare eligible at 65: As one approaches 65, one’s Medicaid case is transferred to the NYC Human Resources Administration (HRA). HRA will mail forms to be completed to assess whether the individual can remain on Medicaid at the lower, non-MAGI levels (see next section). Clients should respond to any HRA mailings if they wish to be assessed for ongoing Medicaid eligibility. HRA will give the individual approximately four months of Medicaid eligibility while the assessment takes place. During this time, clients can use their NYS Benefits Card and access fee-for-service Medicaid from any provider who accepts Medicaid.

Those collecting Social Security benefits will automatically be enrolled in Medicare at age 65. For those not collecting Social Security benefits, they can apply for Medicare Parts A, B and D (Original Medicare or a Medicare Advantage plan) during the 7-month Initial Enrollment Period (see page 5 for more information), since applying for Medicare is a condition of having Medicaid if over 65.

If Medicaid eligibility is denied, one may want to consider joining a Medicare Advantage plan or purchasing a Medigap policy if in Original Medicare. Individuals will have full Extra Help (see page 34) for the remainder of the calendar year. If Medicaid eligibility is approved, the individual has a choice of how to receive their Medicare and Medicaid benefits (see page 45 for information on how Medicare and Medicaid work together).

Medicare due to disability: After receiving 24 months of Social Security Disability Insurance (SSDI) payments, individuals become Medicare eligible and are automatically sent a Medicare card. The Medicaid case gets transferred to NY State of Health to HRA. Clients should now use their NY State Benefits Card and access fee-for-service Medicaid from any provider who accepts Medicaid. Medicare is their primary health insurer, and Medicaid is their secondary insurance. They will maintain Medicaid coverage through the end of their 12-month Medicaid authorization period. HRA will mail forms about three months before the end of the 12-month authorization period 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. Individuals will have full Extra Help (see page 34) for the remainder of the calendar year.

THE ESSENTIAL PLAN

The Essential Plan is for people under age 65 with monthly incomes between 138-200% FPL, estimated at $1,436-$2,081 for individuals/$1,944-$2,818 for a household of two in 2019. Those in the Essential Plan can select a Basic Health Program in which to enroll. Essential Plan coverage includes inpatient and outpatient care, physician services, diagnostic services and prescription drugs among others. Preventive care such as routine office visits and recommended screenings are free.

65 岁符合醫療補助的資格：當個人年滿 65 歲時，其醫療補助個案將轉介至紐約市人力資源行政部 (HRA)。HRA 將會郵寄填寫的表格，以評估該個人是否在更低，非 MAGI 收入水準的標準下繼續取得醫療補助（請參閱下一段）。客戶應該回應任何 HRA 郵件，若他們希望進行後續醫療補助條件評估，在進行評估期間，HRA 將會給予這個人的四個月醫療補助資格，在這個時間內，客戶可以使用紐約州福利卡並從任何接受醫療補助之業者獲得服務費醫療補助。

領取社會安全福利的個人在年滿65 歲時自動被納入聯邦醫療保險。針對年滿 65 歲之時不領取社會福利的個人，在7 個月內的初次註冊期（請參照第 5 頁的更多資訊）申請聯邦醫療保險的 A、B 及 D 部分（聯邦醫療保險原始計畫或聯邦醫療保險優勢計畫），因為超過 65 歲時，申請醫療補助的條件是有聯邦醫療保險。

如果醫療補助資格被否決，當事人可能考慮加入聯邦醫療保險優勢計畫，或是在聯邦醫療保險原始計畫中購買補充保險條款。這些當事人將全部獲得當日曆年度剩餘時間的全額額外補助（請參照第 34 頁），而紐約州衛生署將向其追還繼續參加醫療補助保險之期的 B 部分保費。

如果醫療補助的資格通過，當事人可以決定如何取得他們的聯邦醫療保險以及醫療補助福利（請參閱第 45 頁，以瞭解聯邦醫療保險及醫療補助如何相互運作）。

因殘障而符合醫療補助資格：在領取 24 個月的社会安全殘障保險 (SSDI) 賠償之後，個人即符合聯邦醫療保險資格，並會自動寄送聯邦醫療保險卡。會將醫療補助案例從紐約州衛生署轉至 HRA。客戶現在應使用其紐約州福利卡並從任何接受醫療補助的醫療業者處獲得服務費醫療補助。聯邦醫療保險是其主要健康保險業者，而醫療補助是副保險。他們將會維持醫療補助承保範圍直至其12 個月醫療補助授權期結束。HRA 將會在12 個月授權期結束后的 3 個月前寄發表格，評估醫療補助後階段。建議客戶登記參加最能提供其藥物的 D 部分計畫；若客戶未選擇計畫，他/她將會自動被加入一項計畫，當事人將在日曆年剩餘期限享有額外額外補助（請參照第 34 頁）。

基本計畫

基本計畫針對的年齡未滿 65 歲，收入為 FPL 的 138-200% (預計 2019 年，單身人士約為每月收入介於 $1,436 至 $2,081，兩口之家約為每月收入介於 $1,944 至 $2,818)。處於基本計畫的入員可以選擇一項要加入其中的基本健康計畫。基本計畫承保範圍包括住院病人和門診病人護理、醫生服務、診斷服務和處方藥物等等。預防性護理，例如常規診所訪視和推薦的篩查都是免費的。
Enrollment in the Essential Plan takes place year round.

• Those with incomes 138-150% FPL (monthly incomes estimated at $1,436-$1,561 for individuals/$1,944-$2,113 for a household of two in 2019) pay $0 premium, $0 deductible, and minimal copays for services, with an annual maximum out-of-pocket cost of $200.

• Those with incomes 150-200% FPL (monthly incomes estimated at $1,561-$2,081 for individuals/$2,113-$2,818 for a household of two in 2019) pay $20/month for coverage, $0 deductible, and low copays, with an annual maximum out-of-pocket cost of $2,000.

Essential Plan Enrollees who become Medicare eligible are no longer eligible for the Essential Plan. They will receive a notice from NY State of Health stating that their enrollment is ending. These individuals should enroll in Medicare A, B and D during their 7-month Initial Enrollment Period (see page 5) and may want to consider supplemental insurance coverage.

QUALIFIED HEALTH PLANS

Qualified Health Plans are available for anyone to purchase; those with annual incomes less than 400% of the Federal Poverty Level (estimated at $49,960 for individuals and $103,000 for a family of four in 2019), may be eligible for a Federal subsidy in the form of a tax credit to help pay for the cost of a plan.

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

When can I enroll in a Qualified Health Plan?

Open enrollment for the Marketplace takes place from November 1, 2018 through January 31, 2019. After January 31, you will need to wait for the next annual open enrollment period to enroll. There are certain exceptions that allow you to enroll mid-year, including losing current health insurance coverage.

There are several ways to learn more about Marketplace plans:

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

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

• Visit nystateofhealth.ny.gov.

CALL 311 AND ASK FOR HIICAP

53

符合聯邦醫療保險資格的自願計劃加入者不再符合自願計劃資格，他們將收到紐約州衛生署的通知，稱其登記加入行動將結束。這些個人應該在共7個月的初始登記期內登記加入聯邦醫療保險A、B和D部分（請參閱第5頁），並且可能會需要考慮補充保險。

合格的健保計畫

合格的健保計畫年可供任何人購買；收入未超過聯邦貧窮線的400%（2019年單身人士收入約為$49,960，四口之家收入約為$103,000），便有可能有資格獲以稅收抵免的形式取得聯邦補貼，以幫助支付保險計劃的費用。

保險計劃分為四個”金屬”等級：銅、銀、黃金、白金。各金屬等級的費用分攤（自付額、共付額）條件異異；銅計劃的月保費較低而要求的費用分攤較高；白金計劃的月保費較高而要求的費用分攤較低。

我何時可以登記加入合格的健保計畫？

該市場的開放登記時間為2018年11月1日至2019年1月31日。在1月31日之後，您需等到下一年度的開放登記方可加入。某些特定例外狀況容許於年中登記加入，包含喪失目前的健康保險。

進一步了解健保市場計劃的各種途徑：

• 聯絡「導引者」。導引者屬於社區組織，他們能協助您挑選並登記加入保險計劃。欲尋找附近的導引者，請至https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations 或致電社區健康維護者（Community Health Advocates）1-888-614-5400。

• 聯絡紐約州衛生署（由Maximus運營），電話：1-855-355-5777，週一至週五上午8點至下午5時。

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

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

Beneficiaries are responsible for enrolling in Medicare A, B and D during their Initial Enrollment Period (see page 5 for more information) and for dropping QHP coverage.

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

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

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

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

Beneficiaries are responsible for enrolling in Medicare A, B and D during their Initial Enrollment Period (see page 5 for more information) and for dropping QHP coverage.

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

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

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

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

Beneficiaries are responsible for enrolling in Medicare A, B and D during their Initial Enrollment Period (see page 5 for more information) and for dropping QHP coverage.

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

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

To receive health care at facilities operated by the Department of Veterans Affairs (VA), veterans must be enrolled with the VA. Veterans can apply for coverage at any time. The number of Veterans who can be enrolled in health care program is determined by the amount of money Congress gives VA each year. Since funds are limited, VA set up Priority Group (1-8), based on service history and financial information, to make sure certain groups of Veterans are able to be enrolled before others.

Enrolled Veterans do not need to submit their income information. However, certain Veterans will be asked to complete a financial assessment to determine their eligibility for free medical care, medications and/or travel benefits. This includes: new applicants who are non-service connected and 0% service connected Veterans without special eligibility factors; Veterans who seek exemption from medication copayments; and Veterans who want to establish eligibility for beneficiary travel. In lieu of annual financial reporting, VA will simply confirm the Veteran’s continued ability to pay applicable copayments for health care and medications, as well as eligibility for beneficiary travel benefits, using information obtained from the Internal Revenue Service (IRS) and Social Security Administration (SSA).

Effective 2015, VA eliminated the use of net worth as a determining factor for both health care programs and copayment responsibilities. VA now only considers a Veteran’s gross household income and deductible expenses from the previous year. Elimination of the consideration of net worth for VA health care enrollment means that certain lower-income, non-service-connected Veterans will have less out-of-pocket costs. To learn more about VA national income thresholds and to calculate your specific geographic-based means test (GMT), visit http://nationalincomelimits.vaftl.us/LegacyVAThresholds/Index?FiscalYear=2019.

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

Types of Copayments:

1. Medication: Copayments are broken down into three tiers: Tier 1, preferred generics - $5; Tier 2, non-preferred generics - $8; and Tier 3, brand name medications - $11. All charges are 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.

CALL 311 AND ASK FOR HIICAP

退伍軍人的保險福利與軍人醫療保障 (TRICARE FOR LIFE)

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

登記加入的退伍軍人不需要提交他們的收入資訊。但是，某些退伍軍人需要填寫一份財務狀況評估，以確定他們是否有資格享受免費醫療護理、藥物和/或旅行補貼，包括：患有與服役無關的疾病的新申請者和無特殊資格條件的 0% 服役相關的退伍軍人；要求免除藥費共付額的退伍軍人；以及希望確立受益人旅行補貼資格的退伍軍人。VA 不會評估年度財務報告，而只需要通過從國內收入署（IRS）和社會安全局（SSA）獲得的資訊確認退伍軍人繼續支付相應的健康護理服務和藥物共付額的能力，以及獲取受益人旅行補貼的資格。

從 2015 年起，VA 不再將資產淨值作為健康護理計劃和共付額承受能力的確定因素。VA 現在只考慮退伍軍人家庭的毛收入和上一年的自付總額。VA 健康護理計劃取消資產淨值這一考量因素意味着某些低收入、患有非服役造成的疾病的退伍軍人的自付費用會降低。

2018 年，收入低於 $16,089 的個人可享受免費的 VA 處方藥。收入低於 $32,715 的個人在治療非因服役造成的疾病時可享受免費的 VA 健康護理。欲進一步瞭解 VA 國家收款門檻並計算您所在特定地區的經濟狀況調查結果 (GMT)，請造訪 http://nationalincomelimits.vaftl.us/LegacyVAThresholds/Index?FiscalYear=2019。

不具免費醫療護理資格的退伍軍人須支付共付額。

共付額的種類有：

1. 藥物：共付額分為三個級別：1 級，優選非原廠等同藥 - $5；2 級，非優選非原廠等同藥 - $8；3 級，名牌藥 - $11。針對優先小組 2 至 8 號的退伍軍人，因非服役造成的疾病而在門診所獲得的最大供給量為 30 天護理性藥物，年度共付額上限為 $700，除非另有豁免規定。

2. 門診病人：普通醫療門診共付額為 $15，專科醫療門診共付額為 $50。

3. 住院病人：無論何種服務等級，一年 365 天內的每 90 天護理適用標準共付額付費政策。除此之外，還會評估住院的每日 (每天) 費用。
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.

**TRICARE Health Benefits** provides coverage for active duty service members and their families, service members who died while on active duty, former spouses, and retirees and their families, whether or not the veteran is disabled, and National Guards/Reservist members. TRICARE benefits consist of: TRICARE Prime and Prime Remote; TRICARE Reserve Select, and TRICARE for Life. As of January 1, 2018 TRICARE Select has replaced TRICARE Extra and TRICARE Standard. The programs differ on the use of a provider networks and cost sharing obligations. Most specialty services require prior authorization or referral. Military retirees (and their spouses) have served at least 20 years who are 65 years or older and are currently enrolled in Medicare Parts A and B eligible for TRICARE for Life (TFL). TFL is a premium-free managed health care plan that acts as a supplement to Medicare and includes the TRICARE Express Script Pharmacy program. TRICARE Express Scripts does not cover beneficiaries with a primary commercial pharmacy insurance or Medicare Part D coverage. TFL can be used at the VA but since the VA cannot bill Medicare, the patient is responsible for paying Medicare’s portion of the bill. For more information on TRICARE for Life call 1-866-773-0404 or visit www.tricare.mil. An additional benefit of TRICARE is their dental benefit. TRICARE dental benefits consist of: TRICARE Active Duty Dental Program (ADDP) for Active Duty Service Members who are referred by a military dental clinic (MDC) or who lives more than 50 miles from a MDC, the TRICARE Dental Program (TDP) for ADSM's families, National Guard/Reservist and their family members and the TRICARE Retiree Dental Program (TRDP) is for retired SM's and families.

**Civilian Health and Medical Program (CHAMPVA)** is a health insurance program for dependents of 100% permanently and totally disabled veterans with a service-connected disability. CHAMPVA has an annual deductible or $50 per person or $100 per family per calendar year. In addition, there is a 25% co-insurance. CHAMPVA does not maintain a provider listing. Most Medicare and TRICARE providers will also accept CHAMPVA (but be sure you ask the provider). If eligible for TRICARE, one cannot be enrolled in CHAMPVA. For more information on CHAMPVA, you can call the VA at 1-800-733-8387 or visit www.va.gov.
How Does VA Drug Coverage Interact with Medicare Part D?
VA coverage for prescription drugs is considered creditable, meaning it is as good as, or better than, Medicare Part D. It is possible to have both a Part D plan as well as VA drug coverage. If one chooses to forego Part D and then later wishes to enroll in Part D, there will be no penalty for late enrollment. However, one will need to wait until the annual open enrollment period (October 15 – December 7) to enroll in a plan, unless the individual qualifies for a special enrollment period.

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

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

VA 藥品保險與聯邦醫療保險 D 部分如何交互運作？
VA 處方藥保險為人所稱道，此表示它不亞於，或更優於聯邦醫療保險 D 部分。同時擁有 D 部分計畫及 VA 藥品保險是可行的。若是原先選擇放棄 D 部分計畫，而日後想要加入 D 部分，將不會有延遲登記罰金，但是，必須等到下一年度的開放登記期 (10 月 15 日 – 12 月 7 日) 才能加入某項保險計畫，除非該個體符合某個加入特定登記期的資格。

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

欲進一步了解退伍軍人事務部的健康保險福利，請致電 1-877-222-8387（中部時間上午 7 時至下午 7 時間運）或至 www.va.gov。
OTHER HEALTH COVERAGE OPTIONS FOR NEW YORKERS

COBRA
Federal law requires employers with 20 or more employees to offer COBRA as "continuation coverage" of employer-based health care coverage after you leave your job. In New York State, most people can get COBRA coverage for up to 36 months. COBRA can bridge the gap until you go on Medicare or take a new job that offers health insurance. You can qualify for coverage if you retire, leave your job, get laid off, have your work hours cut, or as a result of the death or divorce from your actively working spouse. Election of continued coverage must take place within 60 days of the notification of COBRA rights. Premiums for COBRA are 102% of what the employer and employee together pay for the plan. Your spouse and dependents are also entitled to benefit from your COBRA coverage.

If you are on COBRA before you become Medicare eligible, COBRA generally stops when Medicare starts. If you are already eligible for Medicare and still working, you may elect COBRA when you stop working, but should enroll in Part B within 8 months following the month you start COBRA coverage in order to avoid Medicare’s late enrollment penalty. If you have both Medicare and COBRA, Medicare is primary and COBRA is secondary. COBRA coverage does not allow someone to delay enrollment in Part B without penalty.

HHC Options
HHC Options is a program through the NYC Health and Hospitals Corporation that allows low and moderate income individuals and families to access health care through HHC’s network of hospitals and health facilities on a sliding fee scale. There is no charge to participate in HHC Options; you only pay when you access care. HHC does not look at immigration status when determining eligibility. For more information, visit http://www.nychealthandhospitals.org/paying-for-your-health-care/hhc-options or call 311 and ask for HHC.

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

CALL 311 AND ASK FOR HIICAP
**Health Insurance & Self Employment**
Some professions offer group rate insurance. Please inquire with your former employer and/or any professional associate memberships to which you belong. Here are a few resources to explore whether or not group plans may be available to you.

<table>
<thead>
<tr>
<th>Small Business Service Bureau</th>
<th>Small business employee</th>
<th>1-800-343-0939 <a href="http://www.sbsb.com">www.sbsb.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Graphic Artists Guild</td>
<td>Graphic Artists</td>
<td>1-212-791-3400 <a href="http://www.gag.org">www.gag.org</a></td>
</tr>
<tr>
<td>National Writers Union</td>
<td>Writers</td>
<td>1-212-254-0279 <a href="http://www.nwu.org">www.nwu.org</a></td>
</tr>
<tr>
<td>Screen Actors Guild</td>
<td>Performers</td>
<td>1-212-944-1030 <a href="http://www.sagaftra.org">www.sagaftra.org</a></td>
</tr>
<tr>
<td>Freelancer's Union</td>
<td>Financial Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nonprofits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Technology Media &amp;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advertising Arts,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Culture or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entertainment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domestic Child Care Giver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traditional or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alternative Health Care Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled Computer User</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>小型企業服務局 (Small Business Service Bureau)</th>
<th>小型企業員工</th>
<th>1-800-343-0939 <a href="http://www.sbsb.com">www.sbsb.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>平面藝術家協會 (Graphic Artists Guild)</td>
<td>平面藝術家</td>
<td>1-212-791-3400 <a href="http://www.gag.org">www.gag.org</a></td>
</tr>
<tr>
<td>全國作家聯盟 (National Writers Union)</td>
<td>作家</td>
<td>1-212-254-0279 <a href="http://www.nwu.org">www.nwu.org</a></td>
</tr>
<tr>
<td>演員工會 (Screen Actors Guild)</td>
<td>表演工作者</td>
<td>1-212-944-1030 <a href="http://www.sagaftra.org">www.sagaftra.org</a></td>
</tr>
<tr>
<td>自由工作者聯盟 (Freelancer's Union)</td>
<td>金融服務</td>
<td></td>
</tr>
<tr>
<td></td>
<td>非營利事業</td>
<td></td>
</tr>
<tr>
<td></td>
<td>科技媒體與廣告藝術，文化</td>
<td></td>
</tr>
<tr>
<td></td>
<td>或娛樂</td>
<td></td>
</tr>
<tr>
<td></td>
<td>家庭托兒業者</td>
<td></td>
</tr>
<tr>
<td></td>
<td>傳統或另類醫療業者</td>
<td></td>
</tr>
<tr>
<td></td>
<td>專業電腦用戶</td>
<td></td>
</tr>
</tbody>
</table>

CALL 311 AND ASK FOR HIICAP
PATIENT RIGHTS AND APPEALS FOR MEDICARE BENEFICIARIES

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

As a Medicare beneficiary, you have the right to:

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

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

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

CALL 311 AND ASK FOR HIICAP
ADVANCE DIRECTIVES
Your Right to Make Health Care Decisions Under the Law

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

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

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

1. **A Health Care Proxy** allows you to appoint another person to make medical decisions for you should you become unable to make those decisions yourself. The “agent” you select needs to be clear about your wishes for treatment, be available if sudden choices need to be discussed, and agree to accept the responsibility if the situation arises. Typically, your doctor or hospital staff cannot be your “agent.”

2. **A Living Will** allows you to explain your health care wishes and can be used to specify wishes regarding life-sustaining treatments or procedures administered to you if you are in a terminal condition or a permanent unconscious state. The document must be signed, dated and witnessed (but not by your doctor or a close relative).

3. **A Do Not Resuscitate (DNR) Order** allows you to specify that you do not want CPR should your heart or breathing stop.

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

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

CALL 311 AND ASK FOR HIICAP

预立醫療指示
法律所規定的個人資料保護

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

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

預立醫療指示是一份文件，記錄您對醫療的選擇，在紐約，有三種預立醫療指示：

1. **醫療護理授權書 (Health Care Proxy)** 讓您指定他人在您無法自行做決定時您做出醫療決定。您所選擇的「代理人」必須清楚您對治療的期望，需要考慮突發性情急時能夠取得連繫，並且同意在任何情況發生時能承擔責任。在一般情況下，您的醫生或醫院的工作者不能成為您的「代理人」。

2. **生前預備 (Living Will)** 讓您能說明自己對醫療護理的期望，並可於特別說明關於使用維生設備延長生命，或是在臨終或永久無意識狀態時所希望接受的處理程序。該份文件必須簽名，註明日期並有兩證 (但不得為您的醫生或近親)。

3. **不施行心肺復甦術 (DNR)** 指示您能特別指明一旦心臟或呼吸停止時，您不希望施行心肺復甦術。

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

按照最新的家庭醫療決定法，家人或密友能以代理人身份代為做出醫療決定，包括代表喪失決定能力、且未預先準備醫療指示表明態度的病患決定，或在治療上未預先準備醫療指示，或廢除維生設備。若有這項新法令，建議紐約人士還是應準備醫療護理授權書，讓指定的「醫療代理人」為失去表達選擇能力者做出醫療決定。代理人必須體察您對經由靜脈和靜脈注射給予營養與水分的意願。
LONG TERM CARE PLANNING

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

What is long-term care?
Long-term care is the kind of daily assistance that an older adult may need when dealing with a prolonged physical illness, a disability, or a cognitive impairment (such as Alzheimer’s disease) that can leave a person unable to completely care for himself.

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

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

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

CALL 311 AND ASK FOR HIICAP

62

Please call 311 and ask for HIICAP
Who pays for long-term care?

Medicare
Medicare’s coverage for long-term care is strictly limited to “medically necessary,” prescribed circumstances.

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

Care in a skilled nursing facility is covered by Medicare Part A when:
1. The beneficiary is admitted within 30 days after a minimum 3-day hospital stay; and
2. The doctor documents that the patient requires a skilled level of care; custodial care can also be involved; and
3. The care is provided in a Medicare-certified skilled nursing facility; and
4. Medicare coverage is for up to 100 days in a benefit period, with cost-sharing between Medicare and the beneficiary from days 21-100.

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

Medicaid
Medicaid is the joint federal/state/city funded program that covers all of the health care and long term care needs of persons with low income and limited assets. To qualify for Medicaid as an individual 65+, blind or disabled residing at home in the community, the individual must apply and document financial eligibility, along with other criteria. The treating doctor must prescribe the need for skilled and personal care.
services which can be provided in the individual’s home. In order for Medicaid to cover the cost of a nursing home stay, the individual must meet the applicable income and resource requirements. Individuals must contribute most of their income to the cost of care, retaining only a modest allowance for personal needs. For more information on Medicaid long term care, see page 46.

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

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

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

**Community spouse protection:** When a husband or wife enters a long-term care facility, the spouse remaining at home is protected from financial impoverishment due to covering the costs of care. Federal and New York State law mandate that the community spouse be allowed to retain the couple’s home, car, personal belongings and a sum of money from their joint assets. In 2019 under Medicaid, the community spouse may retain a minimum of $74,820 and a maximum of $126,400 in assets and $3,160 per month in income. However, when both spouses are in a home care situation, the Community Spouse Protection does not apply. When one or both spouses are receiving care at home under the Medicaid program, they are allowed to keep income and resources only at the Medicaid-eligible levels (see page 43).

By law, states are required to impose estate recovery, which is a claim against the estate of the deceased person, including their home, for what Medicaid paid for the person’s at-home or nursing home care. The claim process cannot begin until after the death of the surviving spouse or surviving minor child.
# MEDICARE 2019

**ORIGINAL MEDICARE DEDUCTIBLES, CO-INSURANCE & PREMIUM AMOUNTS**

### Part A: Hospital Insurance

| Deductible | $1,364 per benefit period |
| Co-Payment | $341 per day for days 61-90 of each benefit period; $682 per day for each "lifetime reserve day" |
| Skilled Nursing Facility Co-Pay | $170.50 per day for days 21-100 of each benefit period |

### Part B: Medical Insurance

Monthly Premium Medicare beneficiaries will pay a premium of $135.50, except for:
- Those whose Social Security Cost of Living Adjustment (COLA) didn't increase enough to raise their Part B premiums to the $135.50 level.
- Higher income (over $85,000 single/$170,000 married) beneficiaries will pay higher amounts.

| Annual Deductible | $185 |
| 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 2019, if you have less than 30 quarters of Social Security coverage, your Part A premium will be $437 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium will be $240 per month.

### Medicare Savings Programs for Low-Income Medicare Beneficiaries (2018)

<table>
<thead>
<tr>
<th>Monthly Income Limit (after any deductions/exclusions)</th>
<th>Individual</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB - Qualified Medicare Beneficiary</td>
<td>$1,032</td>
<td>$1,392</td>
</tr>
<tr>
<td>SLMB - Specified Low-Income Medicare Beneficiary Levels</td>
<td>$1,234</td>
<td>$1,666</td>
</tr>
<tr>
<td>QI - Qualifying Individuals</td>
<td>$1,386</td>
<td>$1,872</td>
</tr>
</tbody>
</table>

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

---

**2019 年聯邦醫療保險**

**聯邦醫療保險原始計劃自付額、共付額及保費金額**

### A 部分：住院保險

| 自付額 | $1,364 (每一段權益期) |
| 共付額 | 每一段權益期的第 61 天至 90 天為每日支付 $341; 每一段“終身儲備期”為每日 $682 |
| 專業護理設施共付額 | 每段權益期的第 21 天至 100 天為每日支付 $170.50 |

### B 部分：醫療保險

- **月保費**: 多數聯邦醫療保險受益人將需要支付 $135.50 的標準保費，除了:
  - 那些其社會安全部門費用調整 (COLA) 沒有增加到足以將其 B 部分保費提高至 $135.50 的入息。“高入息”聯邦醫療保險受益人在 $85,000 (已婚夫妻 $170,000) 需支付較高額的保費。

| 年度自付額 | $185 |
| 共保額 | 大部分為 20% |

有些 65 歲 (含) 以上人士因不符合社會安全局的條件而無免保費住院保險 (A 部分)，並且此一類者，可支付月保費以取得 A 部分。2019 年，若您擁有社會安全部門於 30 個工作季節，A 部分保費將為每月 $437。若您的社會安全部門在 30 至 39 個工作季節，A 部分保費將是每月 $240。

**聯邦醫療保險免保費計劃**

**低收入聯邦醫療保險受益人（2018年）**

<table>
<thead>
<tr>
<th>月收入限制 （減去任何扣除額/抵免之後）</th>
<th>個人</th>
<th>夫妻</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB - 合格聯邦醫療保險受益人計劃</td>
<td>$1,032</td>
<td>$1,392</td>
</tr>
<tr>
<td>SLMB - 特定低收入聯邦醫療保險受益人等級</td>
<td>$1,234</td>
<td>$1,666</td>
</tr>
<tr>
<td>QI - 合格個人計劃</td>
<td>$1,386</td>
<td>$1,872</td>
</tr>
</tbody>
</table>

*如果您所獲的低於上述範圍，但是無意申請醫療補助，也可以申請 QMB。

---

CALL 311 AND ASK FOR HIICAP

---

65
**MEDICAID 2019**

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

<table>
<thead>
<tr>
<th></th>
<th>Monthly Income</th>
<th>Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$859</td>
<td>$15,450</td>
</tr>
<tr>
<td>Couple</td>
<td>$1,267</td>
<td>$22,800</td>
</tr>
</tbody>
</table>

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

**Nursing Home-Based Medicaid**

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

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

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

The community spouse is allowed to retain the following:

**Resources**: $74,820 minimum; $126,420 maximum  **Income**: $3,160.50 monthly

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

---

**Standard Medicaid**

**Medical Assistance 2019**

**Medicaid**

**Income**: When a nursing home resident qualifies for Medicaid support, all income goes to the nursing home except for $50 monthly allowance for the resident’s personal needs.

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

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

The community spouse is allowed to retain the following:

**Resources**: $74,820 minimum; $126,420 maximum  **Income**: $3,160.50 monthly

For more information on Medicaid, call HRA’s Medicaid Helpline at 1-888-692-6116.
Medicaid Offices in New York City

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

Citywide Medicaid Office:
- Central Medicaid Office, 785 Atlantic Avenue, Brooklyn, NY 11238 1-929-221-3502
- Metropolitan Hospital: 1901 First Avenue, 1st Floor, Room 1D-27 (97th Street & 2nd Ave. entrance). (212) 423-7006
- Chinatown Medicaid Office: 115 Chrystie Street, 5 floor. (212) 334-6114
- Manhattanville Medicaid Office: 520-530 West 135th Street, 1st floor. (212) 939-0207

Bronx
- Lincoln Hospital: 234 East 149th Street, Basement, Room B-75. (718) 585-7872
- North Central Bronx Hospital: 3424 Kossuth Avenue, 1st Floor, Room 1A05. (718) 920-1070
- Morrisania Diagnostic & Treatment Center: 1225 Gerard Avenue, Basement. (718) 960-2799

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

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

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

CALL 311 AND ASK FOR HIICAP

紐約市醫療補助辦事處

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

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

曼哈頓
- 大都會醫院 (Metropolitan Hospital)：1901 First Avenue, 1st Floor, Room 1D-27 (39th Street & 2nd Ave.入口) - (212) 423-7006
- 南華醫療補助辦事處：115 Chrystie Street, 5 floor - (212) 334-6114
- Manhattanville 醫療補助辦事處：520-530 West 135th Street, 1st floor - (212) 939-0207

布朗士
- 林肯醫院（Lincoln Hospital）：234 East 149th Street, Basement, Room B-75 - (718) 585-7872
- 布朗士中北區醫院 (North Central Bronx Hospital)：3424 Kossuth Avenue, 1st Floor, Room 1A05 - (718) 920-1070
- Morrisania 診斷和治療中心：1225 Gerard Avenue, Basement - (718) 960-2799

布碌崙
- Coney Island 醫療補助辦事處：3050 West 21st Street - (929) 221-3790
- 東紐約醫療補助診所辦公室：404 Pine Street, 2nd floor - 718-221-8204
- 王家醫院 (Kings County Hospital)：441 Clarkson Avenue, "T" Building, Nurses Residence, 1st Floor. (718) 221-2300
- 布碌崙南部醫療補助辦公室（醫療補助中央辦公室）：785 Atlantic Avenue, 1st Floor - (929) 221-3502

皇后區
- 皇后區社區醫療補助辦事處：32-20 Northern Blvd. (1st Fl.). (718) 784-6729

史坦登島
- 史坦登島醫療補助辦事處：215 Bay Street - (929) 221-8823/8824

請致電 311 溝詢 HIICAP
Medicare Part B and Part D Income-Related Monthly Adjustment Amount (IRMAA) for Higher Income Medicare Beneficiaries

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with a MAGI of $85,000 or less/ Married couples with a MAGI of $170,000 or less</td>
<td>2019 Standard Premium = $135.50</td>
<td>Your Plan Premium</td>
</tr>
<tr>
<td>Individuals with a MAGI $85,000-$107,000/ Married couples with a MAGI $170,000-$214,000</td>
<td>$189.60</td>
<td>Your Plan Premium + $12.40</td>
</tr>
<tr>
<td>Individuals with a MAGI $107,000-$133,500/ Married couples with a MAGI $214,000-$267,000</td>
<td>$270.90</td>
<td>Your Plan Premium + $31.90</td>
</tr>
<tr>
<td>Individuals with a MAGI $133,500-$160,000/ Married couples with a MAGI $267,000-$320,000</td>
<td>$352.20</td>
<td>Your Plan Premium + $51.40</td>
</tr>
<tr>
<td>Individuals with a MAGI $160,000-$500,000/ Married couples with a MAGI $320,000-$750,000</td>
<td>$433.40</td>
<td>Your Plan Premium + $70.90</td>
</tr>
<tr>
<td>Individuals with a MAGI greater than $500,000/ Married couples with a MAGI greater than $750,000</td>
<td>$460.50</td>
<td>Your Plan Premium + $77.40</td>
</tr>
<tr>
<td>Married filing separately with a MAGI $85,000-$415,000</td>
<td>$433.40</td>
<td>Your Plan Premium + $70.90</td>
</tr>
<tr>
<td>Married filing separately with a MAGI $415,000 and greater</td>
<td>$460.50</td>
<td>Your Plan Premium + $77.40</td>
</tr>
</tbody>
</table>

- The Part B Premium + IRMAA 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.

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

CALL 311 AND ASK FOR HIICAP

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

---

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

<table>
<thead>
<tr>
<th>修正調整後年總收入 (MAGI)</th>
<th>B 部分月保費</th>
<th>D 部分 (處方藥) 月保費</th>
</tr>
</thead>
<tbody>
<tr>
<td>個人 MAGI 爲 $85,000 或以下/已婚夫妻 MAGI 爲 $170,000 或以下</td>
<td>2019 年標準保費 = $135.50</td>
<td>您的保費</td>
</tr>
<tr>
<td>個人 MAGI $85,000-$107,000/已婚夫妻 MAGI $170,000-$214,000</td>
<td>$189.60</td>
<td>您的保費 + $12.40</td>
</tr>
<tr>
<td>個人 MAGI $107,000-$133,500/已婚夫妻 MAGI $214,000-$267,000</td>
<td>$270.90</td>
<td>您的保費 + $33.60</td>
</tr>
<tr>
<td>個人 MAGI $133,500-$160,000/已婚夫妻 MAGI $267,000-$320,000</td>
<td>$352.20</td>
<td>您的保費 + $54.20</td>
</tr>
<tr>
<td>個人 MAGI $160,000-$500,000/已婚夫妻 MAGI $320,000-$750,000</td>
<td>$433.40</td>
<td>您的保費 + $74.80</td>
</tr>
<tr>
<td>個人 MAGI 超過 $500,000/已婚夫妻 MAGI 超過 $750,000</td>
<td>$460.50</td>
<td>您的保費 + $77.40</td>
</tr>
<tr>
<td>已婚但分別申請 MAGI $85,000-$415,000</td>
<td>$433.40</td>
<td>您的保費 + $70.90</td>
</tr>
<tr>
<td>已婚但分別申請 MAGI $415,000 及以上</td>
<td>$460.50</td>
<td>您的保費 + $77.40</td>
</tr>
</tbody>
</table>

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

欲取得更多資訊，請造訪社會安全局網站：www.ssa.gov。
## Helpful Health Insurance Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand Name Drug</td>
<td>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.</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>An amount that you must pay for medical care. It is a percentage of the total cost of care.</td>
</tr>
<tr>
<td>Co-payment</td>
<td>A fixed dollar amount that you pay for a medical service.</td>
</tr>
<tr>
<td>Creditable Coverage</td>
<td>Insurance coverage that is as good as, or better than, a basic Medicare Part D drug plan.</td>
</tr>
<tr>
<td>Deductible</td>
<td>An amount that you must pay each year before an insurance policy starts paying.</td>
</tr>
<tr>
<td>Dual eligible</td>
<td>Someone with both Medicare and Medicaid.</td>
</tr>
<tr>
<td>Federal Poverty Level (FPL)</td>
<td>A measure of income issued every year by the federal government. The amounts are used to determine eligibility for certain programs and benefits. The amounts are not adjusted for living in higher cost areas.</td>
</tr>
<tr>
<td>Formulary</td>
<td>A list of drugs covered by a prescription drug plan.</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>A drug that has the same active ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs, and are considered to be as safe and effective as brand name drugs by the federal Food and Drug Administration (FDA).</td>
</tr>
<tr>
<td>Income-Related Monthly Adjustment Amounts (IRMAA)</td>
<td>People with higher incomes are required to pay higher premiums for Medicare Part B and Part D.</td>
</tr>
<tr>
<td>Pre-existing Condition</td>
<td>A health problem that existed before the date your insurance coverage became effective.</td>
</tr>
<tr>
<td>Premium</td>
<td>The amount that you pay for having insurance coverage. You pay the premium regardless of whether you use any health services.</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>Approval which must be obtained beforehand in order for an insurance company to cover a medication or service.</td>
</tr>
<tr>
<td>Quantity Limits</td>
<td>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.</td>
</tr>
<tr>
<td>Step Therapy</td>
<td>A restriction used by a Part D drug plan, requiring you to first try one drug before covering another drug for that condition.</td>
</tr>
</tbody>
</table>

## 有用的健康保险定义

<table>
<thead>
<tr>
<th>有用健康保险定义</th>
<th>有用健康保险定义</th>
</tr>
</thead>
<tbody>
<tr>
<td>原廠品牌藥</td>
<td>具有商品名稱並且受專利保護的藥物，只能由擁有專利的公司進行生產和銷售。</td>
</tr>
<tr>
<td>共保額</td>
<td>必須為醫療護理支付的一筆金額，佔總護理費用的一個百分數。</td>
</tr>
<tr>
<td>其他自付額</td>
<td>每年必須在保單開始支付之前支付的一筆金額。</td>
</tr>
<tr>
<td>具雙重資格者</td>
<td>同時享有聯邦醫療保險和醫療補助的某個人。</td>
</tr>
<tr>
<td>聯邦貧窮線（FPL）</td>
<td>每年由聯邦政府簽發的收入尺度，用於判定某些計劃和福利之合格條件的金額。此類金額不因生活在高費用區域進行調整。</td>
</tr>
<tr>
<td>懲罰集計</td>
<td>懲罰藥物計畫承保藥物之清單。</td>
</tr>
<tr>
<td>非原廠等同藥</td>
<td>其活性成分與非原廠藥相同的一種藥物。原廠藥等同藥的費用通常低於原廠藥品牌，並且被美國聯邦食品藥物管理局 (FDA) 認為與原廠藥牌藥一樣安全和有效。</td>
</tr>
<tr>
<td>非原廠等同</td>
<td>恵方藥物集計 IRMAA 就聯邦醫療保險 B 部分和 D 部分而言，收人較高的人還需要支付較高的費。</td>
</tr>
</tbody>
</table>
Resources for Assistance Paying for Prescription Medications
(Each program can have their own eligibility requirements. Please call or check the website for additional qualifying information and how to apply.)

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

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

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

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

Good Days (formerly Chronic Disease Fund) – Helps people with certain chronic diseases to pay their insurance copays. For more information, and a list of qualifying diseases and medications, visit www.mygooddays.org or call 1-877-968-7233.

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

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

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

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

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

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

CALL 311 AND ASK FOR HIICAP

70

70

70

70

70
Partnership for Prescription Assistance - Helps people access free or low-cost prescription medications. Also provides links for programs that assist with paying co-payments. www.pparx.org or 1-888-4PPA-NOW

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

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

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

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

Other Internet Resources
Department of Labor - Information on COBRA, Black Lung, etc. – www.DOL.gov
Dental Plan Comparison – www.dentalplans.com
Health and Human Services Administration – www.hhs.gov
HealthFinder.gov – Access information specific to different health conditions
Families USA – Information on health care policy – www.familiesusa.org
Kaiser Family Foundation - Information on health care policy – www.kff.org

處方藥協助夥伴 (Partnership for Prescription Assistance) — 協助取得免費或低價的處方藥。也提供連結至協助支付共付額的計畫。造訪 www.pparx.org 或致電 1-888-4PPA-NOW

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

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

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

製藥業共同處方取得計畫 (Together Rx Access) — 為收入符合規定且無聯邦醫療保險和處方藥保險的人士所提供的處方藥折扣卡，www.togetherrxaccess.com。

其他網上資源
勞工部 — 提供關於 COBRA、塵肺病等資訊 — www.DOL.gov
牙醫保險計畫比較 — www.dentalplans.com
健康與人類服務管理局 — www.hhs.gov
HealthFinder.gov — 提供不同病症的專門資訊
美國家庭聯盟 (Families USA) — 提供關於健保政策的資訊 — www.familiesusa.org
凱薩家庭基金會 (Kaiser Family Foundation) — 提供關於健保政策的資訊 — www.kff.org
RESOURCES

NYC HICAP Helpline                                      311 – ask for HICAP
www1.nyc.gov/site/dfta/services/health-insurance-assistance.page
Department for the Aging                                  311
www.nyc.gov/aging
http://web.mta.info/nyct/paratran/guide.htm
Advocacy, Counseling and Entitlement Services Project (ACES)...... 1-212-614-5552
Attorney General Bureau of Consumer Fraud and Protection        1-800-771-7755
www.ag.ny.gov
BigAppleRx Discount Card                               1-888-545-5602
www.BigAppleRx.com
Center for the Independence of the Disabled in New York       1-212-674-2300 or
www.cidadny.org                                              1-646-442-1520
Centers for Medicare and Medicaid Services (CMS)             1-800-MEDICARE
www.cms.gov
Columbia University College Of Dental Medicine’s Teaching Clinic 1-212-305-6100
www.dental.columbia.edu/teaching-clinics
Community Health Advocates                                  1-888-614-5400
www.communityhealthadvocates.org
Eldercare Locator                                             1-800-677-1116
www.eldercare.gov
Elderly Pharmaceutical Insurance Coverage (EPIC)              1-800-332-3742
www.health.state.ny.us/health_care/epic/index.htm
HEAR NOW (provides hearing aids to people with limited resources) 1-800-328-8602
https://www.starkeyhearingfoundation.org/
Health Information Tool for Empowerment (resource directory of free and low cost health and social services) 1-866-370-4483
www.HiteSite.org
Health and Hospitals Corporation (HHC Options)              311
http://www.nychalthandhospitals.org/paying-for-your-health-care/hhc-options/
HRA Info Line – for all HRA programs, including Food Stamps, Public Assistance and Medicaid.... 1-718-557-1399
HRA Medicaid Helpline                                   1-888-692-6116
Hospice Foundation of America                             1-800-854-3402
www.hospicefoundation.org
Independent Consumer Advocacy Network (ICAN) – Medicaid managed long term care ombudsman... 1-844-614-8800
LawHelp.org (to search for legal services, including pro bono) 1-917-661-4500
www.legalservicesnyc.org
Limited Income Newly Eligible Transition (LINET) Program (administered by Humana).............. 1-800-783-1307
Livanta, LLC – (Quality Improvement Organization to appeal hospital discharge and make quality of care complaints)........ 1-866-815-5440

CALL 311 AND ASK FOR HICAP

SOURCE

蘭州的 HICAP 熱線                                      311 — 須詢 HICAP
www1.nyc.gov/site/dfta/services/health-insurance-assistance.page
老人局                                                     311
www.nyc.gov/aging
http://web.mta.info/nyct/paratran/guide.htm
宣傳、諮詢與權益服務方案 (ACES)                          1-212-614-5552
檢察主任公署消費者保護局                                  1-800-771-7755
www.ag.ny.gov
BigAppleRx 折扣卡                                          1-888-454-5602
www.BigAppleRx.com
紐約身心障礙人士獨立中心                                1-212-674-2300 或
www.cidadny.org                                            1-646-442-1520
聯邦醫療保障和醫療補助服務中心 (CMS)                    1-800-MEDICARE
www.cms.gov
哥倫比亞大學牙醫學院教學診所                            1-212-305-6100
www.dental.columbia.edu/teaching-clinics
社區健康維護者                                             1-888-614-5400
www.communityhealthadvocates.org
老年保健指針                                              1-800-677-1116
www.eldercare.gov
老人藥品保險 (EPIC)                                      1-800-332-3742
www.health.state.ny.us/health_care/epic/index.htm
HEAR NOW (為資產有限人士提供助聽器)                     1-800-328-8602
https://www.starkeyhearingfoundation.org/
自主能力健康資訊工具（免費及低收費保健和社會服務資源目錄） 1-866-370-4483
HiteSite.org
健康及醫院網報 (HHC Options)                             311
http://www.nychalthandhospitals.org/paying-for-your-health-care/hhc-options/
人力資源管理局 (HRA) 資訊專線 – 提供所有 HRA 計畫的資訊，包括食物劵，公共援助和醫療補助... 1-718-557-1399
HRA 醫療補助專線                                          1-888-692-6116
美國安寧護理基金會                                      1-800-854-3402
www.hospicefoundation.org
獨立消費者維權網 (ICAN) – 医疗补助管理式长期护理监察      1-844-614-8800
LawHelp.org (搜尋法律服務，包括無償服務)                 1-917-661-4500
紐約市法律服務 (Legal Services NYC)                     1-917-661-4500
www.legalservicesnyc.org
收入有限人士新增資格過渡 (LINET) 計畫 (由Humana管理)    1-800-783-1307
Livanta, LLC — (品質改善組織，進行出院申訴及護理品質投訴) 1-866-815-5440
請致電 311 須詢 HICAP

請致電 311 須詢 HICAP

311 – 質询 HICAP
Medicaid referral for providers accepting Medicaid: 1-800-541-2831
Medicaid facilitated enrollees for Aged, Blind and Disabled (can also help with Medicare Savings Program Applications): 1-347-396-4705
Medicare Fraud Hotline (Office of the Inspector General, DHHS): 1-800-447-8477
Medicare Hotline: 1-800-MEDICARE
Medicare Rights Center: 1-800-333-4114
www.medicarerights.org
National Council on Aging: www.ncoa.org
National Health Information Center: www.health.gov/nhic
New York Connects (long term care services and support; they will make home visits): 1-800-342-9871
Brond (Neighborhood SHOPP): 1-347-862-5200
Brooklyn (JASA): 1-718-671-6200
Manhattan (NY Foundation for Senior Citizens): 1-212-962-2720
Queens (Selfhelp Community Services): 1-718-559-4400
Staten Island (CASC): 1-718-489-3954
New York Legal Assistance Group’s (NYLAG) Evelyn Frank Legal Program:
www.EFLRP@NYLAG.org.
New York State of Health (Marketplace Plan contact): 1-855-355-5777
https://nystateofhealth.ny.gov
NYC Department of Health: 311
www.nyc.gov/health
NYS Long Term Care Ombudsman Program:
https://ltcombudsman.ny.gov
NYS Department of Health-Medicaid and Marketplace HMO complaints: 1-800-206-8125
NYS Department of Financial Services: 1-800-342-3736
www.dfs.ny.gov
NYS Medicaid Helpline:
www.health.ny.gov/health_care/medicaid/
NYS Office for the Aging Senior Citizen Helpline:
www.aging.ny.gov
NYS Office of Crime Victim Services:
https://ovs.ny.gov/help-crime-victims
NYS Department of Health Office of Professional Medical Conduct (physician quality control complaints):
1-800-663-6114
NYU Dental Clinic:
1-212-998-9800
www.nyu.edu/dental
Railroad Retirement Board:
1-877-772-5772
www.rbb.gov
SMP (formerly Senior Medicare Patrol) in NYS:
1-800-333-4374
Social Security Administration:
1-800-772-1213
www.socialsecurity.gov
TTY 1-800-325-0778
United States Department of Veterans Affairs:
1-800-827-1000
www.va.gov

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險轉介接受醫療補助的醫療業者：1-800-541-2831
醫療補助促進的年長、盲目及殘障加入 (還可以協助聯邦醫療保險)
免保費計劃申請)：1-347-396-4705
聯邦醫療保險詐騙熱線 (稽核長辦公室, DHHS): 1-800-447-8477
聯邦醫療保險熱線：1-800-MEDICARE
聯邦醫療保險權益中心：1-800-333-4114
www.medicarerights.org

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

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

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

紐約市衛生局：311
www.nyc.gov/health

紐約州長期護理服務計畫：1-855-582-6769
https://ltcombudsman.ny.gov/

紐約州衛生署－醫療補助及健保市場 HMO 投訴：1-800-206-8125

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

紐約州醫療補助專線：1-800-541-2831

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

紐約州犯罪受害者服務辦公室：1-800-247-8035

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

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

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

紐約州 SMP（原老人醫療保險巡邏計畫）：1-800-333-4374

社會安全局：1-800-772-1213
www.socialsecurity.gov

美國退伍軍人事務部：1-800-827-1000
www.va.gov

請致電 311 招詢 HIICAP
CALL 311 AND ASK FOR HIICAP

74

NOTES