



**Office for  
the Aging**

# **A Quick Reference Guide to HIICAP 2018-2019**

***For HIICAP Counselors Only  
Not for Public Distribution***

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**HIICAP Help Line: 1-800-701-0501**  
**Website: [www.aging.ny.gov/HealthBenefits](http://www.aging.ny.gov/HealthBenefits)**



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



## You're getting a new Medicare card!

**Cards will be mailed between April 2018 – April 2019**

You asked, and we listened. You're getting a new Medicare card! Between April 2018 and April 2019, we'll be removing Social Security numbers from Medicare cards and mailing each person a new card. This will help keep your information more secure and help protect your identity.

You'll get a new Medicare Number that's unique to you, and it will only be used for your Medicare coverage. The new card won't change your coverage or benefits. You'll get more information from Medicare when your new card is mailed.

### Here's how you can get ready:

- Make sure your mailing address is up to date. If your address needs to be corrected, contact Social Security at [ssa.gov/myaccount](https://ssa.gov/myaccount) or 1-800-772-1213. TTY users can call 1-800-325-0778.
- Beware of anyone who contacts you about your new Medicare card. We'll never ask you to give us personal or private information to get your new Medicare Number and card.
- Understand that mailing everyone a new card will take some time. Your card might arrive at a different time than your friend's or neighbor's.

## Medicare Suffixes

Code	Identification	Code	Identification
A	Primary Claimant (wage earner)	F1	Father
B	Aged wife, age 62 or over	F2	Mother
B1	Aged husband, age 62 or over	F3	Stepfather
B2	Young wife, with a child in her care	F4	Stepmother
B3	Aged wife, age 62 or over	F5	Adopting Father
B5	Young wife, with a child in her care, second claimant	F6	Adopting Mother
B6	Divorced wife, age 62 or over	HA	Disabled claimant (wage earner)
BY	Young husband, with a child in his care	HB	Aged wife of disabled claimant, age 62 or over
C1-C9	Child- includes minor, student or disabled	M	Uninsured- Premium Health Insurance Benefits (Part A)
D	Aged Widow, age 60 or over	M1	Uninsured- Qualified for but refused Health Insurance Benefits (Part A )
D1	Aged widower, age 60 or over	T	Uninsured Entitled to HIB (Part A ) under deemed or renal provisions; or Fully insured who have elected entitlement only to HIB
D2	Aged widow ( 2 <sup>nd</sup> claimant)	TA	Medicare Qualified Government Employment (MQGE)
D3	Aged widower ( 2 <sup>nd</sup> claimant)	TB	MQGE aged spouse
D6	Surviving Divorced Wife	W	Disabled Widow
E	Widowed Mother	W1	Disabled Widower
E1	Surviving Divorced Mother	W6	Disabled Surviving Divorced Wife
E4	Widowed Father		
E5	Surviving Divorced Father		

**NOTES:**

## MEDICARE – Part A

### Co-Insurance/Deductible (2018 - Per Benefit Period):

#### Hospital

\$1,340 deductible for each benefit period - Paid upon admission in a hospital		
Day	1-60	\$ 0 coinsurance for each benefit period
Days	61- 90	\$ 335 coinsurance per day for each benefit period
Days	91 & beyond	\$ 670 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime)
Days	Beyond	All costs beyond lifetime reserve days

Benefit Period: A benefit period is the way that Original Medicare measures use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day a person enters a hospital or SNF and ends when they have not received hospital or Medicare-covered skilled care in a SNF for 60 days in a row.

#### Skilled Nursing Facility

Day	1-20	\$ 0 for each benefit period
Days	21-100	\$ 167.50 coinsurance per day of each benefit period
Days	101 & beyond	All costs for each day

If you stop getting skilled care in the SNF, or leave the SNF altogether, your SNF coverage may be affected depending on how long your break in SNF care lasts.

If your break in skilled care lasts **more than 30 days**, you need a new 3-day hospital stay to qualify for additional SNF care. The new hospital stay doesn't need to be for the same condition that you were treated for during your previous stay.

If your break in skilled care lasts for **at least 60 days in a row**, this ends your current benefit period and renews your SNF benefits. This means that the maximum coverage available would be up to 100 days of SNF benefits.

### Eligibility:

Hospital Insurance, known as Part A, is based on you or your spouse's employment history. You are eligible for Part A if you:

Age 65 and Older:

- You or your spouse (or former spouse) had at least 10 years (or 40 calendar quarters) of employment in which you paid Social Security taxes;
- Would be entitled to Social Security benefits based on your spouse's (or divorced spouse's) work record, and that spouse is at least 62 (your spouse does not have to apply for benefits in order for you to be eligible based on your spouse's work); or
- Receive Social Security or railroad retirement benefits;

- Are not getting Social Security or railroad retirement benefits, but you have worked long enough to be eligible for benefit;
- Worked long enough in a Federal, State, or local government job to be insured for Medicare; or

Under Age 65:

- Receive Social Security disability benefits and have amyotrophic lateral sclerosis (Lou Gehrig’s) disease; or
- Have been a Social Security disability beneficiary for 24 months; or
- Been diagnosed with End-Stage Renal Disease (ESRD) and receiving dialysis treatments or have had a kidney transplant; or
- Have worked long enough in a federal, state, or local government job and you meet the requirement of the Social Security disability program.

**Enrollment:**

- For those already receiving Social Security benefits (including Rail Road or disability), enrollment is automatic and would be effective the first of the month in which they turn 65.
- Enroll through Social Security at **1-800-772-1213**. Or on- line <http://www.ssa.gov>.

**Premium (2018):**

\$ 0	40 or more working quarters
\$232.00/month	30-39 quarters of working quarters
\$422.00/month	Less than 30 quarters



**The Qualified Medicare Beneficiary (QMB)** program will pay for a person’s Medicare Part A premium. For more information, please refer to the Medicare Savings Program Section in this guide

## MEDICARE - Part B

**Co-Insurance:** 20% of the Medicare approved amount once the deductible is met.

**Deductible:** \$183.00

### **Eligibility:**

The eligibility rules for Part B depend on whether a person is eligible for premium-free Part A or whether the individual must pay a premium for Part A coverage.

- Individuals who are eligible for premium-free Part A are also eligible to enroll in Part B once they are entitled to Part A. Enrollment in Part B can only happen at certain times.
- Individuals who must pay a premium for Part A must meet the following requirements to enroll in Part B:
  - Be age 65 or older;
  - Be a U.S. resident; AND
  - Be either a U.S. citizen, OR
  - Be an alien who has been lawfully admitted for permanent residence and has been residing in the United States for 5 continuous years prior to the month of filing an application for Medicare

Under Age 65: If you are under the Age of 65, you must meet the same criteria noted above (for persons Age 65 and up) and are receiving Social Security Disability Insurance (SSDI) for more than 24 months, or diagnosed with End-Stage Renal Disease, or Amyotrophic Lateral Sclerosis (ALS).

If a person does not purchase Part B when first eligible, they may face a penalty. (See Late Enrollment Penalty section on the reverse side of this page.)

### **Enrollment Guidelines:**

Enroll through Social Security at **1-800-772-1213** or on-line <http://www.ssa.gov>.

If a person or their spouse is still working and there is active health coverage through the employer, contact the employer's human resource department to learn how Medicare coordinates. A person **may** be able to delay enrollment into Medicare Part B.



If you find a person that does not qualify for one of the below enrollment periods, a **Medicare Savings Program (MSP)** can assist with an **automatic enrollment** into Medicare Part B!

- **General Enrollment Period:** for Part B is from January 1<sup>st</sup> to March 31<sup>st</sup> of each year. Coverage does not begin until July 1<sup>st</sup> of that year.
- **Initial Enrollment Period:** A person has 7 months surrounding their 65th birthday to join Part B (3 months prior to the birthday, the month of the birthday, and 3 months after).

<b>If you sign up for Part A (if you have to buy it) and/or Part B in this month</b>	<b>Your coverage starts:</b>
The month you turn 65	1 month after you sign up
1 month after you turn 65	2 months after you sign up
2 months after you turn 65	3 months after you sign up
3 months after you turn 65	3 months after you sign up
During the January 1–March 31 General Enrollment Period	July 1 <sup>st</sup>

- **Special Enrollment Period (SEP):** Individuals who do not enroll in Part B or premium Part A when first eligible because they were covered under a group health plan based on their own or a spouse's current employment (or the current employment of a family member, if disabled), may enroll during the SEP. The individual can enroll at any time while covered under the group health plan based on current employment, or during the 8-month period that begins the month the employment ends, or the group health plan coverage ends, whichever comes first.
  - If you enroll while covered, or during the first full month after coverage ends, your Medicare Part B will start on the first day of the month you enroll. (You can also delay the start date for coverage until the first day of any of the following 3 months.)
  - If you enroll during any of the 7 remaining months, your Medicare Part B coverage begins the month after you enroll.



Having COBRA **does not** delay the 8-month window to enroll. Client may still be subject to penalty!

**Late Enrollment Penalty:**

- The Late Enrollment Penalty will go up 10 percent for each full 12-month period that a person could have had Part B but didn't sign up for it.
- You can remove the Late Enrollment Penalty if you are eligible for a Medicare Savings Program (MSP). For more information, please refer to the MSP Section in this guide.
- If you are under Age 65 and receiving Medicare Part B with penalty, the Late Enrollment Penalty is waived (removed) at the time of your 65<sup>th</sup> birthday.

**Equitable Relief (or Appeal) for Enrollment or Late Enrollment Penalty:**

The Medicare Rights Center has prepared an excellent summary on how to request equitable relief for immediate enrollment into Part B based on misrepresentation. A summary letter is also provided on the following pages.

**Premium:**

- The standard Part B premium amount in 2018 will be \$134 (or higher depending on your income). However, some people who get Social Security benefits pay less than this amount (\$130 on average). You'll pay the standard premium amount (or higher) if:
- You enroll in Part B for the first time in 2018.
- You don't get Social Security benefits.
- You're directly billed for your Part B premiums (meaning they aren't taken out of your Social Security benefits).
- You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of \$134.)
- Your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount. If so, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium.

If you're in 1 of the 5 groups mentioned above, here's what you'll pay in 2018.

<b>If your yearly income in 2016 (for what you pay in 2018) was</b>			<b>You pay each month in 2018</b>
<b>File individual tax return</b>	<b>File joint tax return</b>	<b>File married &amp; separate tax return</b>	
\$85,000 or less	\$170,000 or less	\$85,000 or less	\$134
above \$85,000 up to \$107,000	above \$170,000 up to \$214,000	Not applicable	\$187.50
above \$107,000 up to \$133,500	above \$214,000 up to \$267,000	Not applicable	\$267.90
above \$133,500 up to \$160,000	above \$267,000 up to \$320,000	Not applicable	\$348.30
above \$160,000	above \$320,000	above \$85,000	\$428.60

**Premiums, How to file for Equitable Relief:**

For Social Security to change their records, a person must show evidence that their income is lower. Evidence can be brought to a local Social Security office or it can be mailed to Social Security. Evidence needs to be accompanied with form SSA-44. <http://www.ssa.gov/online/ssa-44.pdf>

### **Equitable Relief: Navigating the process**

Equitable relief is an administrative process created under federal law that allows people with Medicare to request relief from the Social Security Administration (SSA) in the form of:

- Immediate or retroactive enrollment into Medicare Part B, and/or
- The elimination of your Part B premium penalty

#### **Who can obtain equitable relief?**

For SSA to grant equitable relief, it must determine that your failure to enroll in Part B was:

- “Unintentional, inadvertent, or erroneous” and
- Was the result of “error, misrepresentation or inaction of a federal employee or any person authorized by the federal government to act in its behalf”

For example, if you did not enroll in Part B because a Social Security representative told you that you did not need to enroll, you may have grounds for equitable relief.

#### **How can you request equitable relief?**

In order to request equitable you should write a letter to Social Security explaining that you received misinformation from a federal employee (someone at 800-Medicare, Social Security, or someone acting on the federal government’s behalf such as a Medicare private health plan). You can find the address of your local Social Security office by calling 800-772-1213 or visiting [www.ssa.gov](http://www.ssa.gov).

Be as specific as possible in your letter. Make sure to include the dates and times you spoke with the federal employee or representative and their name if possible. Also be sure to describe the outcome of the conversation. You must also state whether you want coverage going forward or retroactive coverage, and/or the elimination of your Part B penalty. Remember, if you are granted retroactive coverage, you will have to pay premiums back to the time your coverage begins.

You should always keep copies of the documents you send to Social Security. You should also follow up with your local office one month after you submit your letter. If you are having trouble contacting SSA, contact your Senator or Congressperson and ask them to follow up with SSA for you.

#### **Problems with equitable relief**

SSA is not required to respond to your request within any set timeframe, nor is there a formal decision letter that they will send you in response to your request. In the equitable relief process you have no formal rights and you do not have the right to appeal if your request is denied.

Equitable relief is not a formal legal process, but this should not deter you from filing for equitable relief. Many people have been successful in their pursuit of relief.

(See reverse side for a sample letter to SSA)

Sample Letter to SSA for Equitable Relief

**[Print on professional stationery, if possible]**

**[Date]**

Social Security Administration

**[Address of local office]**

Re: Medicare Part B Premium Penalty

Beneficiary: **[Name]**

SSN: **[Social Security Number]**

Dear Sir/Madam:

I am writing to request that the Social Security Administration grant me Equitable Relief by waiving my Medicare Part B premium penalty **and allowing me to enroll in part B effective immediately/retroactive to [specific date]**.

The **[penalty/delay in Part B coverage]** is not reasonable because I followed the rules as they were explained to me by a **[Medicare/Social Security/other federal agency/or federal agent such as a Medicare Private plan]** representative.

**[Explain why you did not enroll in Part B when first eligible. Be as detailed as possible regarding any misinformation you received from Social Security or other federal agency or federal agent such as a Medicare Private plan including names and dates.]** 42 U.S.C. § 1395p(h) states:

In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program... is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such an individual for a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

Pursuant to the above statute, the Social Security Administration should **allow me to enroll in Part B effective [immediately or as of specific retroactive date] AND/OR remove my Part B penalty**]. Thank you.

Sincerely,

**[Your name]**

**[Your title]**

Attachments: **[List any attachments]**

**NOTES:**

## **MEDICARE - Part C**

### **Medicare Advantage Plans**

A Medicare Advantage Plan sometimes referred to as Part C is a type of Medicare health plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

#### **Cost:**

The monthly Part B premium. Some plans charge an extra monthly premium. Your client may also pay the plan a co-payment per visit or service. With an HMO, your client will be responsible for all charges if they go out-of-network except for emergency services, urgent care, and out-of-area dialysis.

#### **Eligibility:**

You must have Medicare Part A and Part B and live in the health plan's service area. A beneficiary will still have the same Medicare rights and protections.

#### **Enrollment Guidelines:**

Please refer to page 29, Medicare Enrollment Period section in this guide.

#### **Types of Medicare Advantage Plans:**

**Health Maintenance Organization – (HMO)** In HMO Plans, you generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network, except: Emergency care Out-of-area urgent care Out-of-area dialysis. In some plans, you may be able to go out-of-network for certain services, but it usually costs less if you get your care from a network provider. This is called an HMO with a point-of-service (POS) option. The plan may require members to get referrals from a primary care physician to see a specialist in their network.

**Preferred Provider Organization- (PPO)** – A Medicare PPO Plan is a type of Medicare Advantage Plan offered by a private insurance company. In a PPO Plan, you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You pay more if you use doctors, hospitals, and providers outside of the network. A member does not have to get a referral to see a specialist

**Private Fee for Service – (PFFS)** A Medicare PFFS is offered by a private insurance company. PFFS plans aren't the same as Original Medicare or Medigap. The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care. Under a PFFS plan, a person with Medicare may go to any Medicare-approved medical provider or hospital that accepts the plan's payment terms. PFFS plans also have networks of providers, no referrals are necessary.

**Specialty Needs Plans**– (SNPs) A Medicare SNP is a type of Medicare Advantage plan that is only available for certain Medicare beneficiaries, such as those with both Medicare and Medicaid (or who are enrolled in a Medicare Savings Program), institutionalized beneficiaries, or those with certain chronic conditions. Special Needs Plans may offer more focused and specialized health care as well as better coordination of care. All SNPs include Part D drug coverage.

**Medical Savings Account** - (MSA) – Medicare MSA plans combine a high deductible Medicare Advantage plan with a medical savings account. The plan deposits an amount annually into an account which can be used for medical expenses. Any unused portion can be carried over to the next year. Once the high deductible is met, the plan pays 100% of covered expenses. Preventive services may not be subject to the deductible and coinsurance. MSA plans do not have a provider network. MSA plan members can use any Medicare provider.



Medicare Supplement/Medigap Policies **DO NOT** coordinate billing with Medicare Advantage Plans.

## MEDICARE - Part D Prescription Coverage

### **Benchmark Amounts:**

2016	2017	2018	2019
\$39.73	\$40.99	\$38.98	\$39.33

### **Best Available Evidence (BAE):**

The Centers for Medicare & Medicaid Services (CMS) created the Best Available Evidence (BAE) policy to address incorrect Low-Income Subsidy (LIS)/Extra cost sharing data in the electronic data systems of CMS, pharmacy and Part D plans. BAE ensures Medicare beneficiaries with LIS aren't charged too much or have higher copayments than expected.

Contact the Plan by using their SHIP designated numbers! These numbers can be found in the directory section in this Guide. The plan must accept proper faxed documentation and update the beneficiaries LIS information at the pharmacy. It can take 2 to 24 hours for the pharmacist's system to be updated.

### **Acceptable Documentation:**

#### **Extra Help (LIS) Eligible Beneficiaries:**

- A letter of award from the Social Security Administration.

#### **Medicaid Eligible Beneficiaries:**

- Copy of beneficiary Medicaid card, with eligibility date.
- A print out from State enrollment file showing Medicaid status during a month after June of previous year.
- A screen-print from the State's Medicaid system or state document showing Medicaid status during a month after June of previous calendar year.

#### **Medicare Savings Program Beneficiaries:**

New York State Department of Health sends an electronic file every month to CMS. We ask that newly awarded beneficiaries wait the expected amount of time for their lower co-pay status to be recognized at the pharmacy. They will be reimbursed the difference for any prescription filled from their effective date.

Exception: If the beneficiary has an expensive drug that they cannot afford, we can ask the State Medicaid Office to send a screen-shot to CMS. This can be done by filling out a CTM and faxing it to NYSOFA at 518-486-2225.



Part D plans may rely on the beneficiary showing the pharmacy a current Medicaid card or other approved information provided by a state Medicaid office as proof of low-income subsidy status.

The Four Phases of 2018 Medicare Part D Plans:

Part D Benefit Costs Periods	Costs and Who Pays
Initial Deductible	\$ 405
Initial Coverage Period (ICP)	\$3,750 (beneficiary pays 25% of retail your plan pays 75%)
Coverage Gap (“Donut Hole”)	You pay 44% of generic retail price and 35% of brand name retail price
Catastrophic Benefit Period	Over 5,000 out-of-pocket Catastrophic Coverage (beneficiary pays approximately 5% of retail)

2018 Coverage Gap Discounts: 65% of brand-name drugs and 56% of Generic drug costs. These discounts will continue through 2020 see chart below:

Year	Generic Benefit	Brand Benefit	Brand Discount
2018	56%	15%	50%
2019	63%	20%	50%
2020	75%	25%	50%
TOTAL	75% Coverage for Both Generic and Brand Drugs		

**Coverage Gap/Donut Hole:**

The gap starts when a person’s TOTAL cost of prescriptions (what the beneficiary and the plan) has paid for covered drugs. In 2018, the coverage gap begins when total drug costs reach \$3,750

**Catastrophic Coverage:**

When a person’s Total Out-Of-Pocket Costs for covered drugs (only what the BENEFICIARY has paid) reaches \$5,000 in 2018. A beneficiary will pay five percent of the cost of each covered drug, or a co-pay of \$3.35/\$8.35, whichever is greater.

**Deductible:** 2018 Deductible \$405

If a person changes plans during a year, their Annual Deductible should carry over from one plan to the next. A person may want to save EOBs and submit proof to the second plan to justify their annual deductible had been met.

**Eligibility:**

You must be enrolled in Medicare Part A and/or B to enroll in Medicare Part D.

### **Enrollment Guidelines:**

Medicare offers prescription drug coverage to everyone with Medicare. If you decide not to get Medicare drug coverage when you're first eligible, you'll likely pay a late enrollment penalty unless one of these applies:

- You have other creditable prescription drug coverage
- You get Extra Help

To get Medicare drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered. There are two ways you can obtain Medicare drug coverage:

1. Medicare Prescription Drug Plan (Part D). These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
2. Medicare Advantage Plan (Part C) (like an HMO or PPO) or other Medicare health plan that offers Medicare prescription drug coverage. You get all of your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs." You must have Part A and Part B to join a Medicare Advantage Plan.

**Enrollment Periods:** See Medicare Enrollment Periods, page 29.

### **Late Enrollment Penalty:**

Generally, a person has 63 days to enroll into a Part D Plan after losing creditable drug coverage through no fault of their own.

The premium penalty will be one percent, of the national premium, for every month you delay enrollment.

2016 National Average Premium = \$34.10

2017 National Average Premium = \$35.63

2018 National Average Premium = \$35.02

2019 National Average Premium = \$33.19

For example, the average national premium in 2018 was \$35.02 a month. If you delayed enrollment for five months, your monthly penalty would be \$1.75. This penalty will be added to the person's plan premium. ( $\$35.02 \times 1\% = \$0.3502 \times 5 = \$1.75$ )



Extra Help can remove a penalty! For more information, please refer to the Extra Help Section in this guide.

### Appealing a Part D Penalty:

To appeal the Part D LEP, you can contact Maximus at the below numbers or mail a written request for reconsideration (be sure to include supporting documentation such as proof of creditable coverage)

MAXIMUS Federal Services  
Part D QIC  
3750 Monroe Avenue, Suite 704  
Pittsford, New York 14534-1302  
Toll Free # 1-877-456-5302  
Fax # 585-869-3320

Maximus is required to make decisions within 30 days of receipt.

### **Limited Income Newly Eligible Transition Program (LINET):**

This program is designed to eliminate any gaps in coverage for low-income Medicare individuals who do not have a Part D plan and are enrolled in Medicaid or Extra Help.

#### **For Pharmacists**

How to Submit Claim to the Limited Income NET Process:

Enter the claim through your claims system in accordance with the Limited Income NET Program Payer sheet, which can be found at:  
<https://www.humana.com/pharmacy/pharmacists/linet>

BIN = 015599

PCN = 05440000

Cardholder ID = Beneficiary HICN Group ID may be left blank

Patient ID = Medicaid ID or Social Security Number

If the pharmacist has Questions, they can go to the LI NET Pharmacy portal at  
<https://www.humana.com/pharmacy/pharmacists/linet> or **Call 1-800-783-1307**

#### **For HIICAP Counselors Only!** – Additional Resources:

[MedicareLINET@cms.hhs.gov](mailto:MedicareLINET@cms.hhs.gov)

1-866-934-2019 eligibility review

Computer Science Corporation (CSC) – NYS Medicaid Payer

For problems at the pharmacy with Medicaid billing 1-800-343-9000

#### **For Beneficiaries** - who need to submit receipts for claims paid out-of-pocket: The

Medicare Limited Income NET Program

PO Box 14310

Lexington, KY 40512-4310

[http://www.cms.hhs.gov/LowIncSubMedicarePresCov/03\\_MedicareLimitedIncomeNET.asp](http://www.cms.hhs.gov/LowIncSubMedicarePresCov/03_MedicareLimitedIncomeNET.asp)

[http://humana.com/pharmacists/resources/li\\_net.asp](http://humana.com/pharmacists/resources/li_net.asp)

**Point of Sale (POS) Facilitated Enrollment:**

See Limited Income Newly Eligible Transition Program (LINET), page 14.

**Low Income Subsidy Prescription Co-Payment Levels:**

2018	Generic	Brand
Level 1	\$3.35	\$8.25
Level 2	\$1.25	\$3.70
Level 3	\$0	
Level 4	15% of drug or co-pay, whichever is less.	

**Transition Policy – 30 Day Supply:**

A transition refill, also known as a transition fill, is a one-time, 30-day supply of a Medicare-covered drug that Medicare Part D plans, must cover.

Transition fills are:

- Temporary,
- Are not for new prescriptions, and
- A person has 90 days after you join a plan to get a transition fill.

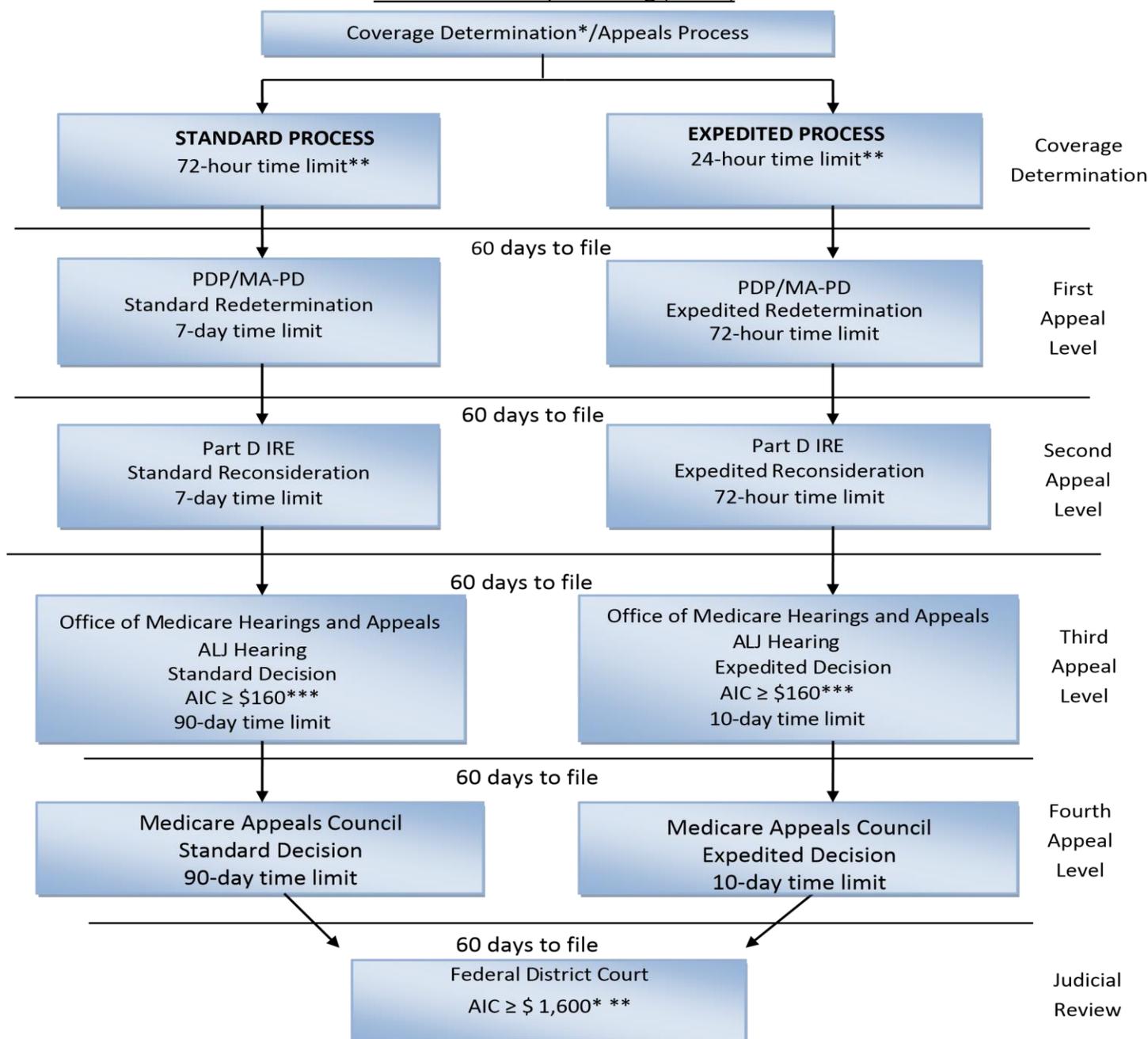
The beneficiary should use the one-time transition fill period to work with their doctor to decide whether it's ok to switch to another drug the plan covers with no limitations, or to request a formulary exception.

**Prescription Appeals Process:**

If a plan denied a request to override a restriction, or move the drug to a lower cost tier (requested an "exception"), you can file appeal. The exception needs to be officially denied in writing. Notice from the pharmacy is not an official denial.

The process for appealing is the same whether you are working with an Advantage Plan or stand-alone private drug plan. A person has 60 days from the date on the "Notice of Denial" to submit an appeal. An appeal process chart is located on the following page

## Medicare Prescription Drug (Part D)



AIC = Amount In Controversy  
 ALJ = Administrative Law Judge  
 IRE = Independent Review Entity

MA-PD = Medicare Advantage plan that offers Part D benefits PDP = Prescription Drug Plan

\*A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, by the enrollee's appointed representative or by the enrollee's physician or other prescriber. \*\*The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.

\*\*\*The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year 2018.

## Managed Long-Term Care (MLTC)

Managed long-term care (MLTC) health plans provide services for some chronically ill New Yorkers and/or those with disabilities. MLTC plans are available on a regional basis to those who have Medicare and Medicaid (dually eligible individuals) and require long-term care services and supports. MLTC is one of several demonstration programs across the country with the goal of providing better and more coordinated care for dually eligible individuals while reducing health care expenditures where possible. MLTC plans are approved by the New York State Department of Health. These plans provide coverage for a number of services, including:

- Home care (including personal care and skilled nursing care)
- Adult day health care (medical only, or medical and social together)
- Home-delivered meals and congregate meals
- Medical equipment, durable medical equipment (DME), eyeglasses, hearing aids, home modifications
- Non-emergency medical transportation
- Podiatry, audiology, dentistry, and optometry, Physical, speech, and occupational therapy and Nursing home care

**Coordination of Benefits:** Having an MLTC plan does not affect your Medicare. This means that Original Medicare or your Medicare Advantage Plan remains your primary payer, paying first for the care you get from hospitals, primary care doctors, and specialists. Your Medicare prescription drug coverage also remains unchanged.

### Eligibility/Enrollment:

Mandatory if beneficiary fulfills all the following:

- Are 21 years or older
- Are dually eligible for both Medicare and Medicaid
- Require long-term care services and supports for more than 120 days
- Live in New York State

Voluntary if:

- Dually eligible individuals age 18 to 20 who meet the other three above criteria



For assistance with MLTC counseling, please contact the **Independent Consumer Advocacy Network (ICAN)** at 844-614-8800 or [ican@cssny.org](mailto:ican@cssny.org) or [ican@cssny.org](mailto:ican@cssny.org).

### State DOH Complaint Lines-

MLTC 1-866-712-7197 or Medicaid Managed Care (MMC) 1-800- 206-8125

For more information, visit:

[http://www.health.ny.gov/health\\_care/managed\\_care/mltc/aboutmltc.htm](http://www.health.ny.gov/health_care/managed_care/mltc/aboutmltc.htm)  
1-888-401-6582

## NOTES:

## **MEDICARE**

### **Other Basic Coverage**

#### **Accountable Care Organizations (ACO's)**

An ACO is a group of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

ACOs are not managed care. A list of ACOs can be found at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html>

#### **Emergency Ambulance Coverage:**

You can get emergency ambulance transportation when you've had a sudden medical emergency, and your health is in danger because you can't be safely transported by other means, like by car or taxi.

The ambulance provider must accept Medicare assignment and bill Medicare direct, meaning they must accept the Medicare-approved amount. Medicare will pay for 80% of its approved amount, and you will be responsible for 20% co-insurance.

**Non-Emergency Ambulance Coverage:** Medicare coverage of a non-emergency situation is limited. You may be able to get non-emergency ambulance transportation if you have a written order from your doctor saying that ambulance transportation is medically necessary. Medicare will never pay for ambulance services.

#### **Limiting Charge – Balanced Billing**

- In New York State, limits apply to the amount a physician may charge a Medicare beneficiary to 105% of the amount approved by Medicare.
- Beneficiary is still required to pay the Medicare deductible and co-insurance
- Law applies to more specialized services and treatments provided in a doctor's office or clinic. Also, applies to all physician treatments and services provided on an inpatient basis in the hospital.
- Does not apply to participating doctors who accept Medicare assignment in all cases.
- Law excludes CPT codes 99201-99215 and 99341-99353, which include routine office or home visits. For these services, the Federal limit of 115% of the Medicare approved amount applies.
- If discrepancies are noted, beneficiaries may request their Medicare Administrative Contractor to review the Medicare Summary Notice (MSN). Review must be requested within 4 months of the date of the MSN. If dissatisfied with the results of the review, beneficiary may seek a higher level of review.
- In New York State, QMB eligible enrollees are not responsible for any Medicare Part B Cost-Sharing.

#### **Coordination of Benefits and Recovery Center (BCRC):**

## 1-855-798-2627 (they accept SHIP Unique IDs!)

If a beneficiary has Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there's more than one payer, "coordination of benefits" rules decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. In some cases, there may also be a third payer.

Coordination of Benefits Recovery Center can assist with Medicare coverage status, auto no-fault, workman's compensation, liability, or a change in insurance coverage or employment status. They can review and update a person's billing information. In some cases, supporting documentation may need to be supplied.

### **Durable Medical Equipment (DME):**

Medicare's **Competitive Bidding Program** for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) changes the amount Medicare pays for certain DMEPOS items. These items include: Oxygen, oxygen equipment and supplies; standard (power and manual) wheelchairs, scooters and related accessories; eternal nutrients, equipment and supplies; Continuous Positive Airway Pressure (CPAP) devices, respiratory assist devices, and related supplies and accessories; hospital beds and related accessories; walkers and related accessories; negative pressure wound therapy pumps, related supplies and accessories; support surfaces.

Diabetic Supplies - Medicare has a National Mail-Order Program for diabetic testing supplies. If a person does not wish to use mail-order, they can still obtain diabetic supplies at a local store. National mail-order contract suppliers can't charge you more than any unmet Part B deductible and 20% coinsurance. Local stores also can't charge more than any unmet Part B deductible and 20% coinsurance if they accept Medicare assignment. Local stores that don't accept assignment may charge you more. If you get your supplies from a local store, check with the store to find out what your payment will be.

DMEPOS applies to individuals on Original Medicare who live in certain counties within New York State.

To find a Medicare approved supplier in your area, go to [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com) or [www.medicare.gov/Supplierdirectory](http://www.medicare.gov/Supplierdirectory)

CMS Publication No. 11461: <https://www.medicare.gov/Pubs/pdf/11461-Medicares-DMEPOS-Program.pdf>

### **Foreign Travel:**

Medicare does not cover medical care outside of the country. If you will be traveling to a foreign country and want insurance, talk to your travel agent about special travel insurance. The only exceptions in which Medicare may cover medical care outside of the U.S. are:

- Medicare will pay for emergency services in Canada if you are traveling a direct route between Alaska and another state.
- Medicare will pay for medical care you get on a cruise ship if:
  - You get the care while the ship is in U.S. territorial waters. This means the ship is in a U.S. port or within six hours of arrival at or departure from a U.S. port.
- Medicare may pay for non-emergency in-patient services in a foreign hospital (and connected physician and ambulance costs). It is covered if it is closer to your residence than the nearest U.S. hospital that is available and equipped to treat your medical condition. This may happen if, for example, you live near the border of Mexico or Canada.

Medigap Coverage Outside the U.S: If you have Medigap Plan C, D, E, F, G, H, I, J, M or N, your plan:

- Covers foreign travel emergency care if it begins during the first 60 days of your trip, and if Medicare doesn't otherwise cover the care.
- Pays 80% of the billed charges for certain medically necessary emergency care outside the U.S. after you meet a \$250 deductible for the year.  
Foreign travel emergency coverage with Medigap policies has a lifetime limit of \$50,000.

### **Foreign Living:**

If a person wishes to reside in another country (foreign living), Medicare will not cover any health services outside of the USA and its territories. The person may want to consider keeping Part B in case they plan to return to the United States. This will eliminate the need to wait until the next Part B enrollment period and any penalties.

### **Home Health Care:**

Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) covers eligible home health services like these:

- Intermittent skilled nursing care
- Physical therapy
- Speech-language pathology services
- Continued occupational services, and more

A beneficiary is typically referred for homecare services by a physician. A Medicare participating home health care agency (HHA) will then perform an assessment to see if the beneficiary meets the Medicare criteria for coverage. (Continued on next page)

The agency will draft a “plan of care”. The plan of care will need to be approved and certified by a doctor.

- You can find a Medicare-approved home health agency at

<http://www.medicare.gov/homehealthcompare/>

- A CMS published booklet on Medicare and Home Health Care can be found at:  
<https://www.medicare.gov/pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf>

### **Home Health Aide:**

Medicare will pay for part-time or intermittent home health aide services (like personal care), if necessary to maintain health or treat an illness. Medicare doesn't cover home health aide services unless also receiving skilled care. Skilled care includes:

Skilled nursing care

Physical therapy

Speech- language pathology services

Continuing occupational therapy, if you no longer need any of the above.

If a person does not qualify to have a Medicare approved aide, there are other programs that will cover this expense, such as Medicaid and the Program of All-Inclusive Care for the Elderly (PACE).

### **Hospice:**

Hospice care is a program of care and support for people who are terminally ill. You can get Medicare hospice benefits when you meet all the following conditions:

- You are eligible for Medicare Part A (hospital insurance), and
- Your doctor and the hospice medical director certify that you are terminally ill and have six months or less to live if your illness runs its normal course, and
- You sign a statement choosing hospice care instead of other Medicare-covered benefits to treat your terminal illness\*, and
- You get care from a Medicare approved hospice program.

The doctor and the hospice medical team will work with the beneficiary and family to set up a plan of care that meets the needs of the beneficiary. When a person chooses hospice care, Medicare will not pay for treatment intended to cure the terminal illness or prescription drugs to cure the terminal illness. \* Medicare will still pay for covered benefits for any health problems that aren't related to your terminal illness.

To find a Hospice program in New York, call 1-800-Medicare or visit [www.medicare.gov](http://www.medicare.gov). You can also refer to CMS' publication on Hospice:

<https://www.medicare.gov/pubs/pdf/02154-Medicare-Hospice-Benefits.pdf>

### **Mental Health:**

Medicare Part A covers inpatient mental health services that you receive in either a psychiatric hospital (a hospital that only treats mental health patients) or a general hospital. Be aware that

you will have the same out-of-pocket costs regardless of whether you receive care in a general or psychiatric hospital. After meeting your Part A deductible, Original Medicare pays in full for the first 60 days of your benefit period. After day 60, you will pay a daily hospital coinsurance.

### **Mental Health Inpatient Stay**

\$1,340 deductible for each benefit period - Paid upon admission in a hospital		
Day	1-60	\$ 0 coinsurance per day of each benefit for each benefit period
Days	61-90	\$ 335 coinsurance per day of each benefit period
Days	91 & beyond	\$ 670 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime)
Days	Beyond	All costs beyond lifetime reserve days
20% of the Medicare approved amount for mental health services you get from doctors and other providers while you’re in the hospital inpatient		

Note: There’s no limit to the number of benefit periods you can have when you get mental health care in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital. Remember, there’s a lifetime of 190 days.

Medicare Part B covers outpatient mental health care, including the following services:

- Individual and group therapy
- Substance abuse treatment
- Tests to make sure you are getting the right care
- Occupational therapy
- Activity therapies, such as art, dance, or music therapy
- Training and education (such as training on how to inject a needed medication or education about your condition)
- Family counseling to help with your treatment
- Laboratory tests
- Prescription drugs that you cannot administer yourself, such as injections that a doctor must give you
- An annual depression screening.

### **Non-Covered Medicare Services:**

- **Alternative medicine**, including experimental procedures and treatments, acupuncture, and chiropractic services (other than manual subluxation of the spine);
- **Most care received outside of the United States;**
- **Cosmetic surgery** (unless it is needed to improve the function of a malformed part of the body);
- **Most dental care;**
- **hearing aids** or the examinations for prescribing or fitting hearing aids (except for implants to treat severe hearing loss in some cases);

- **Personal care or custodial care**, such as help with bathing, toileting and dressing (unless homebound and receiving skilled care) and nursing home care (except in a SNF, if eligible);
- **Housekeeping services to help you stay in your home**, such as shopping, meal preparation, and cleaning (unless you are receiving hospice care);
- **Non-medical services**, including hospital television and telephone, a private hospital room, canceled or missed appointments, and copies of x-rays;
- **Most non-emergency transportation**, including ambulette services;
- **Transportation**, except for medically necessary ambulance services; and
- **Most vision (eye) care**, including eyeglasses (except when following cataract surgery) and examinations for prescribing or fitting eyeglasses.

### **Filing Direct Medical Payment Claims to Medicare – 1490s**

To obtain Medicare payment or receive a Medicare denial notice, beneficiary's need to send their original bill along with any other proper documentation (ask the doctor to code the bill and list the medical condition) to:

National Government Services, Inc. PO Box  
6178  
Indianapolis, IN 46206-6178

A copy of the 1490s form can be found at:

<http://www.cms.gov/cmsforms/downloads/cms1490s-english.pdf>

Medicare claims must be filed no later than 12 months (or one full calendar year) after the date when the services were provided.

## COMPLAINTS

Where to Report What!

**Advertisements:** Are you suspicious of any advertisements or mailings that beneficiaries receive? If so, **fax** a copy to NYSOFA at 518-486-2225.

**Agent Misrepresentation:** If you feel that a sales agent pressured or misled a beneficiary into enrolling in a plan, please report the name of the agent and their company to:

On-Line At:

<http://www.dfs.ny.gov/consumer/fileacomplaint.htm>

When preparing a complaint to the Insurance Department, remember that your “exact language” may become part of the complaint. Avoid personal and inflammatory language!

### **Medicare Marketing:**

[Surveillance@cms.hhs.gov](mailto:Surveillance@cms.hhs.gov)

Carbon copies to [Rachel.Walker@cms.hhs.gov](mailto:Rachel.Walker@cms.hhs.gov) and State HIICAP Office

### **Medicare Part A and Part B Issues:**

[RONYBeneficiary@cms.hhs.gov](mailto:RONYBeneficiary@cms.hhs.gov)

### **Medicare Part D Issues:**

[PartDComplaints\\_RO2@cms.hhs.gov](mailto:PartDComplaints_RO2@cms.hhs.gov)

### **Medigap-Supplemental Issues:**

NYS Dept. of Financial Services (formerly known as NYS Insurance Department)

<http://www.dfs.ny.gov/consumer/fileacomplaint.htm>

### **Original Medicare and/or Medicare Summary Notice Billing Concerns:**

The New York Senior Medicare Patrol (SMP) is part of a nationwide education and assistance program working to empower seniors and caregivers to prevent, detect, and report Medicare fraud and waste. You can report suspected problems to SMP. Contact New York Senior Action Council at 1-877-678-4697.

### **Prescription Concerns with Medicare Advantage Plans and PDPs:**

Health Integrity, 1-877-772-3379, 410-819-8698 (fax)

### **Provider Errors:**

Phone the provider. This may be the hospital, physician, facility or anyone who received payment from Medicare. Explain your concern for a review.

**How to report Medicaid Fraud Allegations:** There are several ways to report an allegation:

- E-mail: [BMFA@omig.ny.gov](mailto:BMFA@omig.ny.gov)
- Toll-free: 877-873-7283
- Fax: 518-408-0480
- Internet: [www.omig.ny.gov](http://www.omig.ny.gov)
- Mail: NYS OMIG – Bureau of Medicaid Fraud Allegations  
800 North Pearl Street  
Albany, NY 12204

\*\*More information on reporting Medicaid fraud can be found in the Medicaid section.

## MEDICARE ENROLLMENT PERIODS

### **5 Star Special Enrollment Period:**

December 8<sup>th</sup> until November 30<sup>th</sup>

- One time SEP during these dates.
- People can switch to a 5-Star Medicare Advantage plan (with or without drugs), a 5-Star Medicare Prescription Drug plan at any time during the year.
- People currently enrolled in a plan with a 5-Star overall rating may also switch to a different plan with a 5-Star overall rating.
- People with Original Medicare, with or without Part D, may also use this SEP to pick up a 5 Star PDP or 5 Star Medicare Advantage for the first time.
- Enrollment is effective is the first day of the following month.

### **Annual Election Period (AEP):**

October 15<sup>th</sup> to December 7<sup>th</sup>

- A person can drop, pick-up or switch any health plan options
- To be effective January 1<sup>st</sup> of the following year

### **General Enrollment Period (GEP):**

January 1<sup>st</sup> to March 31<sup>st</sup>

- For individuals who missed their Medicare Part B IEP.
- Coverage is effective July 1<sup>st</sup>.

### **Initial Enrollment Period (IEP):**

- For individuals upon first meeting the eligibility requirements for Medicare.
- Has seven months to enroll into Medicare. The IEP begins three months before the person meets the eligibility requirements and ends three months following that month.

### **Medicare Advantage Open Enrollment Period (MA OEP)**

January 1<sup>st</sup> to March 31<sup>st</sup>

- Beneficiaries on a Medicare Advantage Plan (with our without Part D) can switch to either another Medicare Advantage Plan or to Original Medicare.
- Effective the 1<sup>st</sup> of the following month.

Note: CMS has discontinued the Medicare Advantage Disenrollment Period (MADP) as of January 1, 2019.

### **Special Enrollment Periods:**

Due to CMS amending rules for some special enrollment periods for 2019, please refer to the Special Enrollment Chart developed by the Medicare Rights Center to view the special enrollment periods available. This chart can be found at:

[http://www.medicareinteractive.org/uploadedDocuments/mi\\_extra/SEP-Chart.pdf](http://www.medicareinteractive.org/uploadedDocuments/mi_extra/SEP-Chart.pdf)

**NOTES:**

## MARKETING

### **Marketing Rules: Educational Events:**

No plan marketing activities at educational events!

- Event advertising materials must include disclaimer.
- No sales activities, or distribution/acceptance of enrollment forms and/or business reply card.

Plans may distribute:

- Promotional gifts (retail valued at \$15 or less).
- Medicare and/or health educational materials.
- Agent/broker business cards, upon beneficiary request.  
(not contain benefit information.)

### **Sales Events:**

Plans may:

- Accept and perform enrollment.
- Distribute health plan brochures and pre-enrollment materials.
- Formally present benefit information.
- Provide nominal gifts to attendees (retail value at \$15 or less).
- Accept one-on-one appointment if beneficiary has requested.

### **Marketing in Health Care Settings:**

No plan marketing activities in healthcare setting.

- No sales activities or distribution/acceptance of enrollment forms.
- Examples: waiting rooms, exam rooms, hospital patient rooms, dialysis centers, pharmacy counter areas.

Marketing allowed

- In common areas, such as: hospital or nursing home cafeterias, community or recreational rooms, conference rooms.
- By providers, per current CMS Marketing Guidelines.
- 

### **Sales event cancellation notice to beneficiaries:**

- If event cancelled within 48 hours of originally scheduled date and time, must have a representative at the site.
- If event cancelled more than 48 hours prior to its originally scheduled date and time, should notify beneficiaries of the cancelled event using same means the plan used to advertise the event.
- Agent should remain at scheduled events for at least 15 minutes after the scheduled start time before leaving an event that is cancelled due to non-attendance.

### **Unsolicited Contacts Prohibited Activities:**

- Calls to confirm receipt of mailed information.
- Approaching in common areas such as parking lots, hallways, lobbies, etc.
- Calls/visits after attendance at sales event, unless express permission given.
- Calls to former members to market plans or products.
- Plan sponsors may not e-mail prospective members at an email address obtained through friends.
- Leaving leaflets, door hangers or flyers at a prospect's home or on a car prohibited (Although leaving leaflets, door-hangers or flyers at someone's residence is prohibited, agents who have a "no show" from a prescheduled appointment may leave information the door).
- Plan sponsors may not conduct unsolicited calls to their Medigap enrollees regarding their MA or PDP products.

### **Unsolicited Contacts Permitted Activities:**

Calls to:

Existing members to conduct normal business related to plan.

Former members for disenrollment survey.

- Only after disenrollment effective date.
- No sales or marketing information.

Members by the agent/broker who enrolled them in the plan.

Beneficiaries who have given express permission.

(All plan sponsors are required to conduct outbound verification calls to new enrollees.)

### **Where to Report When a Possible Violation is Found:**

[Surveillance@cms.hhs.gov](mailto:Surveillance@cms.hhs.gov)

Carbon copies to [Rachel.Walker@cms.hhs.gov](mailto:Rachel.Walker@cms.hhs.gov) and State HIICAP Office.

## MEDIGAPS

**HIICAP Counselor** - If you have any questions on Medigap policies, you can contact Sarah Allen with the New York State Department of Financial Services at:

Sarah L. Allen, Supervising Insurance Attorney  
NYS Department of Financial Services,  
Insurance Division, Health Bureau  
One Commerce Plaza  
Albany, NY 12257  
518-486-7815, 518-474-3397 (fax)  
[Sarah.Allen@dfs.ny.gov](mailto:Sarah.Allen@dfs.ny.gov)

### **The Public/Consumer:**

For general questions or complaints, the public should call 1-800- 342-3736 or 212-480-6400 in New York City.

### **Eligibility:**

To be eligible for a Medigap, you must be enrolled in both Part A and Part B.

***Remember, Medigap insurance will only pay if Medicare pays!***

Note: For a person to qualify for AARP's United Healthcare's Medigap, a person must be a member of AARP and at least 50 years old.

### **Open Enrollment in New York State:**

New York State law and regulation require that any insurer writing Medigap insurance must accept a Medicare enrollee's application for coverage at any time throughout the year. Insurers may not deny the applicant a Medigap policy or make any premium rate distinctions because of health status, claims experience, medical condition or whether the applicant is receiving health care services.

### **Waiting Periods in New York State:**

Medigap policies may contain up to a six (6) month waiting period before the pre-existing condition is covered. A pre-existing condition is a condition for which medical advice was given or treatment was recommended or received from a physician within six months before the effective date of coverage. However, under NYS regulation, the waiting period may either be reduced or waived entirely, depending upon your individual circumstances. Medigap insurers are required to reduce the waiting period by the number of days that you are were covered under some form of "creditable" coverage so long as there were no breaks in coverage of more than 63 calendar days. Coverage is considered "creditable" if it is one of the following types of coverage:

- A group health plan;
- Health insurance coverage;
- Medicare\*;
- Medicaid;
- CHAMPUS AND TRICARE health care programs for the uniformed military services;
- A medical care program of the Indian Health Services or tribal organization;

- A state health benefits risk pool;
- A health benefit plan issued under Peace Corps Act; and
- Medicare supplement insurance, Medicare select coverage or Medicare Advantage.

\*Credit for the time that a person was previously covered under Medicare shall be required only if the applicant submits an application for Medigap insurance prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B.

### **List of Medigap Plans and Rates in New York State:**

For a list of Medigap plans in New York State, please go to the following website:

<http://www.dfs.ny.gov/>

### **Dis-enrolling from a Medigap plan:**

Medigap policies cannot work with Medicare Advantage Plans. If you have a Medigap policy and join a Medicare Advantage Plan (Part C), you may want to drop your Medigap policy. Your Medigap policy can't be used to pay your Medicare Advantage Plan copayments, deductibles, and premiums.

**How to Cancel:** Contact your insurance company. If you leave the Medicare Advantage Plan, you might not be able to get the same Medigap policy back, or in some cases, any Medigap policy unless you have a "trial right."

If you have a Medicare Advantage Plan, it's illegal for anyone to sell you a Medigap policy unless you're switching back to Original Medicare. Contact your State Insurance Department if this happens to you.

If you want to switch to Original Medicare and buy a Medigap policy, contact your Medicare Advantage Plan to see if you're able to dis-enroll.

If you join a Medicare Advantage Plan for the first time, and you aren't happy with the plan, you'll have special rights to buy a Medigap policy if you return to Original Medicare within 12 months of joining.

- If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.
- The Medigap policy can no longer have prescription drug coverage even if you had it before, but you may be able to join a Medicare Prescription Drug Plan (Part D).
- If you joined a Medicare Advantage Plan when you were first eligible for Medicare, you can choose from any Medigap policy.



## Medigap Plan Benefits

For plans sold on or after June 1, 2010

	A	B	C	D	F*	G	K**	L**	M	N
<b>Hospital Copayment</b> Copay for days 61-90 (\$335) and days 91-150 (\$670) in hospital; Payment in full for 365 additional lifetime days	.	.	.	.	.	.	.	.	.	.
<b>Part B Coinsurance</b> Coinsurance for Part B services, such as doctors' services, laboratory and x-ray services, durable medical equipment, and hospital outpatient services	.	.	.	.	.	.	50%	75%	.	Except \$20 for doctors visits and \$50 for emergency visits
<b>First three pints of blood</b>	.	.	.	.	.	.	50%	75%	.	.
<b>Hospital Deductible</b> Covers \$1,340 in each benefit period	.	.	.	.	.	.	50%	75%	50%	.
<b>Skilled Nursing Facility (SNF) Daily Copay</b> Covers \$167.50 a day for days 21-100 each benefit period	.	.	.	.	.	.	50%	75%	.	.
<b>Part B Annual Deductible</b> Covers \$183 (Part B deductible)	.	.	.	.	.	.	.	.	.	.
<b>Part B Excess Charges Benefits</b> 100% of Part B excess charges. (Under federal law, the excess limit is 15% more than Medicare's approved charge when provider does not take assignment; under New York State law, the excess limit is 5% for most services)	.	.	.	.	.	.	.	.	.	.
<b>Emergency Care Outside the U.S.</b> 80% of emergency care costs during the first 60 days of each trip, after an annual deductible of \$250, up to a maximum lifetime benefit of \$50,000.	.	.	.	.	.	.	.	.	.	.
100% of coinsurance for Part B-covered preventive care services after the Part B deductible has been paid	.	.	.	.	.	.	.	.	.	.
<b>Hospice Care</b> Coinsurance for respite care and other Part A-covered services	.	.	.	.	.	.	50%	75%	.	.

\* Plan F also offers a high-deductible option in which you pay a \$2,240 deductible in 2018 before Medigap coverage starts.

\*\* Plans K and L pay 100% of your Part A and Part B copays after you spend a certain amount out of pocket. The 2018 out-of-pocket maximum is \$5,240 for Plan K and \$2,620 for Plan L.

**Note:** Plans E, H, I, and J stopped being sold June 1, 2010. If you bought a Medigap between July 31, 1992 and June 1, 2010, you can keep it even if it's not being sold anymore. Your benefits are different from what's on the chart above. This chart also doesn't apply to Massachusetts, Minnesota and Wisconsin. Those states have their own Medigap systems.

**NOTES:**

## PROBLEM RESOLUTION

- 1) **Call the Plan** – With your SHIP User Unique ID, you can discuss personal information regarding a client with the Plan. Plans have designated direct SHIP telephone numbers for counselors to call. See the Directories Section to obtain a list of dedicated numbers.

Even with your Unique ID, you will still need to provide the beneficiary's name, address (including zip-code) and date of birth.

- 2) **Call the CMS SHIP Number** - **1-888-647-6701**  
With your SHIP Unique ID, you can discuss personal information regarding a beneficiary with Medicare Representatives.

It will ask you to enter your SHIP Unique ID.

Medicare representatives at this number **cannot** retro-enroll or retro- dis-enroll beneficiaries. These types of cases can only be handled by CMS.

- 3) **Medicare Rights Center (MRC)** - NYSOFA has contracted with MRC to provide technical assistance.
  - Medicare Interactive – [www.medicareinteractive.org](http://www.medicareinteractive.org)
  - MRC HIICAP Coordinator Hotline – 1-800-480-2060.
  - Technical Assistance Email – [hiicap@medicarerights.org](mailto:hiicap@medicarerights.org).

- 4) **NYSOFA HIICAP Unit** - Don't hesitate to call our office!

Brenda LaMere 518-474-6085  
Heather Leddick 518-474-2401  
Helen Fang 518-473-3002

[Brenda.LaMere@aging.ny.gov](mailto:Brenda.LaMere@aging.ny.gov)  
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- 5) **Complaint Tracking Module (CTM) Form** - If you have a case and need assistance from NYSOFA, please fill out a **detailed** complaint on a CTM and fax to NYSOFA at 518-486-2225. A copy of the latest CTM is located on the following page. You **MUST** include the contract numbers related to the complaint (ex. S5983-006) and provide your **direct** telephone number so we can reach you.

Date: \_\_\_\_\_

Issue Level:

(Date complaint received)

- Immediate (Less than 2 days of meds)
- Urgent (3-14 days of meds left)

- MA
- PDP

**SHIP CTM Pilot - MA or Part D Complaint Report**

**Information about Person Making this Report:**

Complaint Source County: \_\_\_\_\_

Counselor: \_\_\_\_\_

Direct phone # \_\_\_\_\_

E-Mail \_\_\_\_\_

**Beneficiary Information:**

Name: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number#: \_\_\_\_\_

Email: \_\_\_\_\_

Name of Plan/Contract #: (Example: S5555 or H2222-001) \_\_\_\_\_

Please note: We will not process the CTM without this information

Date of Incident: \_\_\_\_\_

Nature of Complaint: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

End Result – Indicate what you hope to accomplish (person dis-enrolled as if plan never existed, return to previous MA/PDP plan etc...) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## THErapy LIMITS

### Medicare Coverage for Outpatient Physical, Occupational and Speech Therapy

Medicare Part B (Medical Insurance) helps pay for medically necessary outpatient physical and occupational therapy, and speech-language pathology services.

#### **Your costs in Original Medicare:**

- You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Medicare law no longer limits how much Medicare pays for your medically necessary outpatient therapy services in one calendar year. However, your therapist will need to add information to your therapy claims if your therapy services reach these amounts in 2018:

- \$2,010 for physical therapy (PT) and speech-language pathology (SLP) services combined
- \$2,010 for occupational therapy (OT) services

#### **The therapy limits apply to outpatient therapy received at:**

- Therapists' or physicians' offices;
- Outpatient hospital, and
- Home, when not part of a Medicare-covered home health benefit.

**Once your therapy services reach these amounts, your therapist will need to add a special code to your therapy claim. By adding this code, your therapist confirms that:**

- Your therapy services are reasonable and necessary
- Your medical record includes information to explain why the services are medically necessary

**A Medicare contractor may also review your medical records to be sure your therapy services were medically necessary. This review may happen if your therapy services reach these amounts in 2018:**

- \$3,000 for PT and SLP services combined
- \$3,000 for OT services

**NOTES:**

## Elderly Pharmaceutical Insurance Coverage (EPIC) Program

Helpline: 1-800-332-3742  
Provider line: 1-800-634-1340  
Albany Office: 518-452-3773  
Fax: 518-452-3576  
Mailing Address: EPIC  
PO Box 15018  
Albany, New York 12212-5018

Email: [EPIC@health.state.ny.us](mailto:EPIC@health.state.ny.us)

Website: [http://www.health.ny.gov/health\\_care/epic/](http://www.health.ny.gov/health_care/epic/)

EPIC is New York State program that helps income-eligible seniors with their out-of-pocket Medicare Part D drug plan costs. In 2018, EPIC will continue to provide supplementary drug coverage for Part D and EPIC covered drugs after any Part D deductible is met. EPIC will also continue to cover Part D excluded drugs such as prescription vitamins and prescription cough and cold preparations.

### **Eligibility:**

To join EPIC, a senior must:

- Be a [New York State resident](#) age 65 or older; and
- Have an [annual income](#) below **\$75,000** if single or **\$100,000** if married; and
- Be enrolled or eligible to be enrolled in a Medicare Part D plan (no exceptions); and
- Not be receiving full Medicaid benefits.

Note: EPIC income is based on prior year's income. No change in circumstances will apply.

### **EPIC Has Two Plans Based On Income:**

#### **EPIC Fee Plan:**

The Fee Plan is for members with income up to \$20,000 if single or \$26,000 if married. Members pay an annual fee to EPIC ranging from \$8 to \$300 based on their prior year's income. This fee is billed in quarterly installments or can be paid annually. Members with

Full Extra Help will have their EPIC fee waived. All fee plan members will receive Medicare Part D assistance up to \$39.00 in 2018. Non-payment of EPIC fees will result in loss of EPIC benefits.

### **EPIC Deductible Plan:**

The Deductible Plan is for members with income ranging from \$20,001 to \$75,000 if single or \$26,001 to \$100,000 if married. Members must meet an annual EPIC deductible based on their prior year's income before they pay EPIC co-payments for drugs.

EPIC pays the Medicare Part D drug plan premiums up to \$39.00 in 2018 for members in the Deductible Plan with incomes ranging from **\$20,001 to \$23,000 if single or \$26,001 to \$29,000 if married.**

Deductible Plan members with income between **\$23,001 to \$75,000 if single or \$29,001 to \$100,000 if married** are required to pay their Medicare Part D plan premium each month. To provide Part D premium assistance, the member's EPIC deductible is reduced by the annual cost of a basic benchmark Part D drug plan (in 2018, \$468.00)

### **What Benefits Does EPIC Provide?**

#### **Premium Assistance**

- EPIC will pay the Medicare Part D premiums up to the benchmark amount (\$39.00 in 2018) for members with incomes up to \$23,000 if single and \$29,000 if married. If a member's income is above these amounts, then EPIC will not pay the Medicare Part D premium.
  - If you are approved for the full or partial Extra Help, EPIC will provide additional premium assistance up to the benchmark amount (\$39.00 in 2018) if Extra Help does not cover the entire premium.
- If you are in a Medicare Advantage Plan, EPIC will only pay up to the benchmark amount of the drug portion. EPIC will not contribute toward the Part C premium.

If an EPIC member qualifies for premium assistance and receives a letter from their plan indicating they will be cancelled for non-payment, immediately contact BOTH their Medicare Part D plan and the EPIC Helpline at 1-800-332-3742. The helpline representative will contact the plan to make sure the member is not in danger of being cancelled from their Part D plan.

## Drug Coverage

- EPIC provides supplemental coverage for Medicare Part D and EPIC covered drugs.
- Part D excluded drugs such as prescription vitamins and prescription cough and cold preparations will also be covered. EPIC will supplement the member's Initial Coverage Period, Coverage Gap and the Catastrophic Coverage Period. EPIC will not supplement drugs purchased in the Medicare Part D deductible phase, if the member's plan has one.
- EPIC members should show the pharmacist their Part D and EPIC cards. Members must be sure to use a pharmacy or mail-order pharmacy that participates in both EPIC and their Part D plan, since EPIC only covers drugs purchased at participating pharmacies.
- EPIC co-payments range from \$3 to \$20 and are based on the cost of the prescription remaining after being billed to the Medicare Part D drug plan. For example, for a drug that costs \$100 at the pharmacy, the member will pay \$20. Below is the EPIC co-payment schedule:

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

### **EPIC Enrollees Must Also Have Medicare Part D Coverage**

While enrollment for Medicare Part D takes place only at certain times during the year, seniors can apply for EPIC at any time of the year. EPIC members are **required** to be enrolled in a Medicare Part D drug plan (stand-alone) or a Medicare Advantage health plan with Part D.

### **EPIC's One-Time Special Enrollment Period (SEP)**

EPIC enrollees who are not already in a Part D plan at the time of EPIC enrollment, will receive a Special Enrollment Period (SEP) so that they can sign up for a Part D plan at that time.

Note: EPIC enrollees who are already in a Part D plan have a SEP, in which they have the option of switching Part D plans once per calendar year. This switch is in addition to the Annual Election Period for Part D which takes place October 15-December 7 of each year. You must maintain EPIC coverage and be enrolled in a

Medicare Part D drug plan in order to receive benefits. If you disenroll from your Medicare Part D drug plan either by request or due to failure to pay, you must re-enroll in a Medicare Part D plan or you will not receive EPIC benefits for the remainder of the year.

### **EPIC and Employer/Retiree Drug Coverage:**

EPIC requires Part D plan enrollment; as such, these individuals are not eligible for EPIC, since enrollment in a Part D plan would compromise their employer/retiree coverage.

However, if the Employer/Retiree drug coverage is a Part D plan they would be able to have EPIC supplement their Part D covered drugs. Check with the benefits manager to find out what drug coverage they have.

### **EPIC and Extra Help:**

EPIC will provide assistance to members who have been identified as income eligible for Extra Help, EPIC can apply to the Social Security Administration for Extra Help on their behalf, and provide a Medicare Savings Program (MSP) application and assist in completing, upon request.

The benefits of having EPIC together with Extra Help include:

- EPIC fees are waived for members with Full Extra Help.
- Additional savings on generic drugs (\$3.35) lowered to \$3.00; brand name drugs (\$8.35) lowered to \$3.00.
- Medicare pays Part D premiums up to \$39.00 (2018), EPIC pays up to an additional \$39.00 (2018).

EPIC will pay the de-minimis amount for all members that qualify for EPIC's premium assistance.

### **Enrolling in EPIC**

- You can call EPIC at 1-800-332-3742 (TTY 1-800-290-9138) to request an application.
- Visit [www.health.ny.gov/health\\_care/epic/application\\_contact.htm](http://www.health.ny.gov/health_care/epic/application_contact.htm) to download and print an application. You can also submit an online request for EPIC to mail you an application.
- You can ask your pharmacists for an application.

No need for expedited applications! EPIC applications are processed on average under two weeks. Any applicant needing immediate coverage should contact EPIC

## 2018 EXTRA HELP

### Enrollment:

- On-Line Application: <https://secure.ssa.gov/i1020/start>
  - Hard Copies: Social Security created applications that have special ink for scanning purposes. Photocopies will not be accepted. Original forms only.



Denied because your assets are too high? Try enrolling the beneficiary into the Medicare Savings Program (MSP)! MSP eligibility automatically qualifies a person for Extra Help and it has no asset test! For more information, see the MSP section in this guide.

If you have Medicare and Medicaid and/or a Medicare Savings Program

You are enrolled in...	And your income is....	Then you get...	Your 2018 copays are
Medicaid	Up to \$1,032 (\$1,392 for couples) per month in 2018 <sup>1</sup>	Full Extra Help \$0 premium and deductible <sup>2</sup>	\$1.25 generic copay \$3.70 brand-name copay No copay after \$5,000 in out of pocket drug costs
Medicaid and/or the Medicare Savings Program	Above \$1,032 (\$1,392 for couples) per month in 2018 <sup>1</sup>	Full Extra Help \$0 premium and deductible <sup>2</sup>	\$3.35 generic \$8.35 brand-name copay No copay after \$ 5,000 in out of pocket costs

If you have Medicare only

And your income is...	And your assets are....	Then you can get...	Your 2018 copays are...
Up to \$1,386 (1,872 for couples) per month in 2018 <sup>1</sup>	Up to \$9,060 (\$14,340 for couples) in 2018 <sup>3</sup>	Full Extra Help \$0 premium and deductible <sup>2</sup>	\$3.35 generic copay \$ 8.35 brand name copay No copay after \$5,000 in out of pocket drug costs
Below \$1,538 (\$2,078 for couples) per month in 2018 <sup>1</sup> <ul style="list-style-type: none"> <li>• And your income and /or assets are above Full Extra Help limits</li> </ul>	Up to \$14,100 (\$28,150 for couples) in 2018 <sup>3</sup> <ul style="list-style-type: none"> <li>• And your income and/or assets are above Full Extra Help limits</li> </ul>	Partial Extra Help Premium depends on your income \$ 83 deductible or the plan's standard deductible whichever is cheaper	15% coinsurance or the plan copay, whichever is less. After \$5,000 in out of pocket drug costs, you pay \$3.35 /generic and \$8.35/brand-name or 5% of the drug costs

**Note:** Income and asset limits on this chart are rounded to the nearest whole dollar. There's also a \$20 income disregard (factored into the income limits above) that the Social Security Administration automatically subtracts from your monthly unearned income.

<sup>1</sup> Income limits are based on the Federal Poverty Level (FPL), which changes every year in February or March. Limits are higher for each additional relative living with you for whom you are responsible.

<sup>2</sup> You pay no premium if you have Full Extra Help and a basic Part D drug plan with a premium at or below the Extra Help premium limit for your area.

<sup>3</sup> Asset limits include \$1,500 per person for burial expenses

**NOTES:**

## MEDICAID

(Medicare and those with Medicaid = Dual Eligible)

### **Billing:**

- Doctor must always accept Medicare assignment on claims.
- Beneficiary cannot be balance billed for the 20% Medicare co-insurance and deductibles, if doctor/provider accepts Medicaid or if beneficiary is a Qualified Medicare Beneficiary (QMB).
- Doctor may be able to refuse to accept client for future visits.
- Medicaid Billing Concerns: Computer Science Corp – 1-800-343-9000.

**Eligibility:** The below figures do not include any income disregards i.e., \$20 unearned income disregard.

2018	Income Below	Resources Below
Single:	\$ 842 per month	\$ 15,150
Couple:	\$ 1,233 per month	\$ 22,200

- A Dual Eligible must have Part D.
- Spend-Down – also known as “Excess Income” or incurred Medical Expense Deduction
  - Individuals who have excess income need to spend-down a certain amount of money by incurring medical expenses each month before becoming or remaining eligible for Medicaid. (More information on Medicaid Spend-Down is located in this section.)



The **Medicaid Look-Back** for skilled nursing facilities is five (5) years. Transfers made within the 5 years before admission to a nursing home and application for nursing home Medicaid may cause a “transfer penalty” for a period of time based on the amount transferred. This means that Medicaid will not pay for nursing home care during the penalty period. No 5 year lookback or transfer penalties apply to Home and community Based Services (HCBS), managed long-term care (MLTC), the Medicaid Assisted Living Program, or any other community-based Medicaid services.

### **Part A and Part B Coordination:**

- Automatic Medicaid Crossover – Medicare’s Coordination of Benefits will now automatically cross-over and submit unpaid expenses to Medicaid.
- Medicaid supplements Medicare coverage by paying out-of-pocket Medicare cost-sharing (co-insurance and deductibles) to providers who accept Medicaid, and by providing services and supplies not covered by Medicare or after Medicare benefits are exhausted.
- Some but not all Medicaid beneficiaries are also Qualified Medicare Beneficiaries (QMB). (Those with incomes above 100% Federal Poverty Line may be able to spend down for Medicaid but their income is too high for QMB). Some people have only QMB but not Medicaid. For QMB beneficiaries, Medicaid will pay out-of-pocket Medicare cost-sharing expenses to providers who accept Medicaid. If a provider does not accept Medicaid, the provider may not balance-bill a QMB beneficiary.
- Medicaid eligible beneficiaries may qualify for the SLMB and QMB assistance programs. Please refer to the Medicare Savings Program in this resource guide to learn more about these programs.

### **Part C – Medicare Advantage Plan Coordination:**

Medicare Advantage plans usually do not contract directly with the State and therefore present a grey area when it comes to secondary payer for billing issues. There is no automatic cross over as with original Medicare.

Medicaid Advantage Special Needs Plans are designed to work specifically with a dual eligible. They contract directly with the state government. They wrap-around the Medicare Advantage plans to stream-line the billing process for duals.

Duals should always be screened for QMB or SLMB so they should not be responsible for the Part B premium, and, for QMBs, for Medicare cost-sharing.

Note: If the dual has a spenddown, enrolling into QMB or SLMB will increase their spenddown. Spenddown clients should be given the choice of whether they want the Part B premium paid directly on their behalf through the MSP or whether they want to continue paying the premium and having the cost deducted from their income to reduce their spenddown.

The Medicare Advantage premium is a combination of Part C premium (MA) and Part D. A dual eligible will be deemed for Extra Help and the Part D premium component of the Medicare Advantage plan will be subsidized up to the benchmark amount. Neither Extra Help nor Medicaid will cover additional Part C premiums above the benchmark amount.

### **Part D – Prescription Drug Coverage Coordination:**

- If a dual eligible does not join a prescription drug plan, they will be automatically and randomly assigned into a benchmark drug prescription plan.
- If they choose not to participate in a prescription drug plan, they may lose all their Medicaid benefits.
- If a dual eligible has creditable drug coverage through his/her employer or union or his/her spouse, they are not automatically enrolled into a Part D plan. This is to prevent duals from jeopardizing their employer or union coverage.

### **Medicaid coverage of prescriptions for the Dual Eligible Population:**

Only drugs that are excluded by law from being covered by the Medicare Part D plans, such as select prescription vitamins and over-the-counter drugs are covered by NYS Medicaid for dual eligible patients (Medicare/Medicaid).

Claims for over-the-counter medications and prescription vitamins can be billed by the pharmacist directly to Medicaid as they are not covered under the Medicare Part D benefit.

A list of drugs that can be billed directly to Medicaid for dual eligible beneficiaries can be found on the following page or at:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_transition/docs/2015\\_06\\_15\\_medicare\\_exempt\\_drugs.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_transition/docs/2015_06_15_medicare_exempt_drugs.pdf) and

[http://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy\\_Procedure\\_Codes.pdf](http://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Procedure_Codes.pdf)

### **Part D Drugs:**

Medicaid does not provide dual eligible patients with coverage of Part D-covered medications. Even if a dual eligible's Part D plan does not cover a specific Part D drug (because it is not in the formulary, or requires prior authorization or step therapy), Medicaid will not cover the drug.

### **Compound Medications:**

Medicaid also does not cover compound prescriptions for the dually eligible population. Patients and providers should consult the appropriate Medicare Part D prescription drug plan or Medicare Advantage Prescription Drug Contracting (MAPD) plan for coverage of compounded prescriptions for medically accepted indications. Medicaid will cover compounded prescriptions for NYS Medicaid beneficiaries who are not Medicare eligible.

### **“Best Available Evidence” of Medicaid or Extra Help Eligibility Policy:**

If a dual eligible, or LIS recipient, receives the incorrect cost- share level at the pharmacy, the Plan must override the subsidy-level data and apply the appropriate cost-sharing level until CMS’ systems are updated. The pharmacist or beneficiary must contact or fax the appropriate information to the Plan. For more information on this policy, see the Best Available Evidence Policy in the Medicare Part D section.

### **LINET:**

When a dual eligible goes to the pharmacy and there is no evidence of a Part D plan, but clear evidence of both Medicare and Medicaid, the pharmacist is required to bill LINET - Humana Contractor. A 31-day supply of the drug will be provided. Pharmacists can call 1-800-783-1307 for assistance. For more information on this opportunity, see the LINET/Point of Sale in the Medicare Part D section.

### **Special Enrollment Period (SEP):**



- A dual may switch to a different plan **once per quarter for the first three quarters of the calendar year**. For example, a person can use it once in January – March, once in April – June, and once in July – September.
- A dual may choose and switch to a different plan once they are notified of a change of LIS or Dual status.
- A dual may choose and switch to a different plan if they were assigned by CMS or their State (e.g., auto-assigned, reassignment, passive enrollment).

### **Spend-Down:**

If a person’s income is above the Medicaid limit, client may qualify for Medicaid by incurring medical bills in an amount that equals the monthly spend-down. To calculate the spend-down, the spouse’s income also counts if they live together, unless the spouse does a “spousal refusal.”

- The spend-down must be met each month to have ongoing Medicaid.
- The spend-down must be met just once to receive Extra Help for the entire calendar year. If that person meets this one-time spend-down in August or later, they will receive Extra Help for the rest of that year and the following calendar year.
- A bill only needs to be incurred to count toward the spend-down. It does not have to be paid. The date the medical service occurred is what counts, not the date of the bill.
- Medical bills, including the client and their spouse, can be considered (even if the spouse is not applying for Medicaid). However, if the spouse requested a “spousal refusal,” then you may not use the spouse’s bills.

- Bills for any dependent child under age 21 can be used toward Spend-down.
- Deductibles and coinsurance for Medicare, Part D or other private health insurance can be used.
- Services that are medically necessary such as chiropractors, podiatrists, drugs the Part D plan won't cover, bills of doctors who don't take Medicaid, and Over the counter items can be used to meet the spend-down.
  - EPIC – EPIC expenses and the amount EPIC pays (not just the client's co-payment, counts toward spend-down). This includes 3 months before the month client applies for Medicaid.
- Hospital bills – To cover an inpatient hospital stay, even for just one night, Medicaid requires individual to meet SIX months' spend-down instead of ONE MONTH. This is true for Medicaid to cover the Medicare Part A hospital deductible.
- While people already on Medicaid may only utilize bills incurred in the current month to meet the spend-down for that month, there is a special rule for new applicants. They may use:
  - Paid bills (for the 3 calendar months prior to the month of application). These past due bills can be used to meet the spend-down for up to six months beginning in the month of application, or beginning up to 3 calendar months prior to the month of application. These paid bills may also be reimbursed by Medicaid once the spend-down is met, if the provider accepts Medicaid.
  - Unpaid medical bills (no time limit, can be very old bills, as long as they are viable meaning doctor can sue to collect the money). These bills may be used to meet the spend-down beginning in the month of application, or beginning up to 3 calendar months prior to the month of application. There is no limit on the length of time these bills can be used to meet the spend-down. For example, if Mary has a \$200/month spend-down and had a \$2,000 dental bill five months before she applies for Medicaid, the bill can be used to meet the spend-down for 10 months, beginning in the month of her application or, at her option, 3 calendar months before she applies.

### **Spousal Impoverishment:**

The expense of nursing home care, which ranges from \$8,000 to \$16,000 a month or more, can rapidly deplete the lifetime savings of elderly couples. In 1988, Congress enacted provisions to prevent what has come to be called "spousal impoverishment," which can leave the spouse who is still living at home in the community (the "community spouse") with little or no income or resources if all of the "sick" spouse's income and resources are used to pay for their nursing home care.

These provisions help ensure that community spouses are able to live out their lives with independence and dignity.

Spousal impoverishment protections have been extended to community spouses of individuals receiving Home and Community Based Services (HCBS) waiver, or Medicaid managed long term care (MLTC), or “Immediate Need” personal care or Consumer Directed Personal Assistance Program (CDPAP) services.

The spousal impoverishment provisions apply when one member of a couple (the “Medicaid spouse”) enters a nursing facility and is expected to remain there for at least 30 days, **or** is receiving HCBS waiver, MLTC, or “Immediate Need” personal care or CDPAP services.

**Resource Eligibility:** When the Medicaid Spouse in a nursing facility applies for Medicaid or “Immediate Need” personal care or CDPAP services, or enrolls in an HCBS waiver or MLTC plan, an assessment of both spouses’ individually owned and joint resources is made. The couple’s resources, regardless of ownership, are combined.

**EXEMPT RESOURCES:** The couple’s home, household goods, an automobile, pre-paid funeral agreements for each spouse, and a burial fund of up to \$1500 for each spouse are not included in the couple’s combined resources.

The Medicaid Spouse may keep resources up to the single resource limit used in the community. (2018- \$15,150) plus a pre-paid funeral agreement and \$1500 burial fund or life insurance with cash value up to \$1500. If the Medicaid Spouse has more resources solely in his/her name or held jointly with the spouse, the Medicaid spouse may transfer resources that exceed the resource limit (\$15,150 - 2018) to the Community Spouse. Transfers to anyone else may cause a “transfer penalty.”

The Community Spouse may keep \$74,820 of the couple’s combined resources, plus a pre-paid funeral agreement and \$1500 burial fund or life insurance with a cash value of up to \$1500, and the home. If the Community Spouse has more than \$74,820, then she may keep up to one-half of the couple’s combined resources up to \$123,600. If the couple has more resources, they may consult an elder law attorney for other options. These may include the community spouse seeking an order of support, or requesting a fair hearing to allow the spouse to keep more resources in order to generate interest income if the spouse’s income is otherwise below the minimum monthly maintenance needs standard. (See Income Eligibility below).

If there are excess countable resources, they may be considered available to the Medicaid spouse as countable resources. Once resource eligibility is determined, any resources belonging to the community spouse are no longer considered available to the spouse in the medical facility.

Because the couple is married, the home is exempt as long as the Community Spouse is residing there, regardless of its value. For single person seeking MLTC or HCBS services, the equity limit for the home is below \$828,000 (2018).

**Income Eligibility:** A Medicaid spouse may use all or part of his or her income to support the community spouse, depending on the spouse's own income. If the community spouse has his or her own income that is less than the "minimum monthly maintenance needs allowance" [MMMNA] (\$3,090/month in 2018), then the community spouse may keep his/her own income plus enough of the Medicaid spouse's income to bring the total up to the MMMNA level. This is called the "community spouse monthly income allowance" (CSMIA).

The MMNA is calculated after applying allowable deductions. If the community spouse's income exceeds the MMNA, Medicaid will ask for a contribution of 25% over that amount for the Medicaid spouse's care. For MLTC and waiver programs, if the community spouse's income exceeds the MMNA, Medicaid can do a comparison budget treating the Medicaid spouse as a household of one and only counting his/her income. Medicaid should choose the budgeting that is most advantageous.

In a nursing home, the Medicaid spouse may keep only \$50/month plus enough to pay any Medigap or other health insurance programs.

For MLTC and waiver programs, the Medicaid spouse may keep \$391/mo. and enough to pay any Medigap or other health insurance premiums.

**Spousal Refusal:** If client is married and spouse does not need or qualify for Medicaid, client may still apply if spouse refused to make income and resource available. With spousal refusal, budget is considered "Single." Note – county may have the right to sue "refusing" spouse for support. Each county has different policies.

### **Special Income Deduction for People Who Left a Nursing Home or Adult Home and Enrolled in an MLTC Plan**

If an individual was in a nursing home or an adult home for 30 days or more, and Medicaid paid toward the nursing home care, and now the individual is discharged home and enrolls in an MLTC plan, they may keep an additional amount of income to pay for their rent or mortgage. This reduces or even eliminates their spend-down. The current amounts -- which vary by region in the state -- are posted in this article - <http://www.wnylc.com/health/entry/212/> . One cannot use both this housing deduction and "spousal impoverishment" budgeting – must pick one or the other.

### **Pooled Income Trusts – Can reduce the Spend-Down**

An individual, whether married or single, with a spend-down may enroll in a Pooled Income Trust to reduce or eliminate the spend-down. These trusts are sponsored by non-profit organizations. The person who enrolls in the trust may deposit their spend-down into the trust every month. For a small fee, the trust then pays the individual's rent or other expenses. Once the individual enrolls, the trust must be submitted to the local Medicaid program with forms that show that the individual is disabled. One form must be signed by the individual's physician and the other is completed by the

applicant explaining the individual's work, educational and medical history. For more information see <http://www.wnylc.com/health/entry/44/>.



Fact Sheet on Pooled Trusts to Reduce the Medicaid Spend-down  
– download at <http://www.wnylc.com/health/entry/6/>

## MEDICARE SAVINGS PROGRAM 2018

The incomes included in the charts include a \$20 disregard:

### **Qualified Medicare Beneficiary Program (QMB):**

- Pays for the Medicare Part A and/or Part B premiums.
- Medicare providers should not bill QMB's for Medicare cost-sharing.
- Individuals may also be eligible for Medicaid
- There is no resource test.
- Original Medicare and Medicare Advantage providers who do not accept Medicaid must still comply with improper billing protections and cannot bill QMB's
- Does not offer retroactive premium reimbursement
- Effective the first of the month after application.

QMB	Income Below
Single:	\$1032 per month
Couple:	\$1392 per month

### **Specified Low Income Medicare Beneficiary Program (SLIMB):**

- Pays for the Medicare Part B premium only.
- Individuals may also be eligible for Medicaid (with a spend-down)
- The applicant must have Medicare Part A
- There is no resource test.
- Offers up to three months of retroactive premium reimbursements.

SLMB	Income Below
Single:	\$1,234 per month
Couple:	\$1,666 per month

### **Qualified Individual (QI):**

- Pays for the Medicare Part B premium.  
Individuals cannot be eligible for QI and Medicaid.
- The applicant must have Medicare Part A.
- There is no resource test for this program.
- Offers up to three months of retroactive premium reimbursement within same year as the effective date.

QI	Income Below
Single:	\$1,386 per month
Couple:	\$1,872 per month

### **Qualified Disabled and Working Individual (QDWI):**

- This program pays for the Medicare Part A premium.
- The applicant must be a disabled worker under age 65 who lost Part A benefits because of return to work.

QDWI	Income Below	Resources Below
Single:	\$ 4,132 per month	\$ 4,000
Couple:	\$ 5,572 per month	\$ 6,000

### **MSP Helpful Hints:**

- Automatic Enrollment into Extra Help
- Automatic removal of any Part D late enrollment penalty
- To obtain the latest version of the Medicare Savings Application:

<https://www.health.ny.gov/forms/doh-4328.pdf>

<b>Proof of Income:</b>	
Earned Income from Employer	Current paycheck/stubs (4 consecutive weeks) or letter from employer
Self-Employment Income	Current signed income tax return or record of earnings and expenses
Rental/Roomer-Boarder Income	Letter from roomer, boarder, tenant or check stub
Unemployment Benefits	Award letter/certificate, benefit check, correspondence from NYS Dept. of Labor Statement from pension/annuity.
Private Pensions/Annuities	Statement from pension/annuity
Social Security	Award letter/certificate, benefit check, correspondence from SSA
Child Support/Alimony	Letter from person providing support, letter from court, child support/alimony check stub
Worker's Compensation	Award letter, check stub
Veteran's Benefits	Award letter, benefit check stub, correspondence from VA
Military Pay	Award letter, check stub
Support from Family Members	Signed statement and/or letter from family member
Income from a trust	Trust document
<b>Citizenship/Identity</b>	
Identity	Copy of front and back of you or your spouse's
Citizenship	A copy of your Medicare card (also serves as a
Immigrant/Lawful Permanent Resident (LPR)	Immigration documentation such as USCIS form
<b>Residency/Home Address</b>	
ID card with address	Postmarked non-window envelope, postcard, magazine label with name, address and date
Driver's license issued within past 6 months	Utility bill within last six months (gas, electric, cable), or correspondence from a govt. agency
School Record	
<b>Health Insurance Premiums</b>	
Letter from Employer, Premium Statement or Pay Stub	

## Medicare Savings Program Budgeting

### Earned Income

- Count wages, salary and earning from self-employment and
- Count less than half of your clients earned income (subtract \$65 from gross EARNED monthly income, then divide remaining income in half).

### Unearned Income

- Count Gross Social Security – before the Part B premium is deducted,
- Count Pensions, including disability pensions,
- Count Income from retirement accounts only if asset pays out on a regularly and is not automatically reinvested like as an IRA or annuity.
- **Do Not** count interest earned on checking or savings accounts.

### Disregards

- Income that does not count for a person's budget.
- Certain monetary amounts that can be subtracted from a person's monthly income.
- Earned and unearned income disregards.
- Food stamps or cash assistance.
- In-kind income (except for legally responsible relatives living outside of the home). (not including the part allocated to Part D)

### Disregard for Health Insurance Premiums

- Subtract the monthly premium for other insurances such as:
  - Medigap premiums
  - Medicare Advantage Month Premium
  - Any remaining Part D premium that is “above the benchmark”
  - Long Term Care Insurance
  - Union Health Fund Premiums
  - Dental Insurance/Major Medical

You cannot use the Part B premium as a health insurance disregard!

### Household Sizes:

In 2010, NYS DOH modified its rules so that all married individuals will be considered a household size of TWO. DOH GIS 10 MA 10 (regardless of whether spouse is also aged, blind or disabled). Except if:

- Couple is not living together and
- One spouse is permanently residing in a nursing home

### Interest:

Do Not count interest on most resources such as checking /savings accounts and CDs. Because this is an ongoing issue, please refer to the following page that includes references for justification.

## INCOME

### **Unearned:**

**Description:** Unearned income is income which is paid because of a legal or moral obligation rather than for current services performed. It includes pensions, government benefits, dividends, interest, insurance compensation and other types of payments.

**Policy:** The available net amount of unearned income, in addition to any other countable income, is compared to the appropriate income level.

**References:** SSL Sect. 366.2  
Dept. Reg. 360-4.3

**Interpretation:** The following types of unearned income are described in detail in this section: Unemployment Insurance Benefits;  
NYS Disability Benefits and Workers' Compensation  
Social Security, Railroad Retirement,  
Veterans' Benefits; Dividends and interest;  
Private pensions/Retirement Funds;  
Union benefits;  
Support payments (voluntary and court-ordered); Contributions from relatives and friends;  
Income from rental of property; Military  
Dependency allotments;  
and  
Reverse Mortgages.

Unearned income is verified as to the amount, type and frequency, and the information is documented in the case record.

**Disposition:** When the gross unearned income has been determined, disregards are deducted to result in available net unearned income. This, in addition to any other countable income, is then compared to the appropriate income level in determining eligibility for Medicaid.

**APPLICANT**

Please print clearly and do not write in the dark shaded area.

First Name, Middle Initial, Last Name			Home Phone		
Home Address Street	Apt. No.	City	State	Zip Code	County
Is this a shelter? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Mailing Address Street/P.O. Box (If Different from Above)	Apt. No.	City	State	Zip Code	County

**NAMES**

List your name first. Include aliases and maiden name. If necessary, attach an extra sheet to list all children.

First Name, Middle Initial, Last Name	Date of Birth (MM/DD/YY)	Sex	Social Security Number	Race/Ethnic Group (See Codes Below)
Self				
Spouse				
Child*				
Child*				

\*If under 18 years of age.  
Race/Ethnic: A: American Indian or Alaska Native B: Black, Not of Hispanic Origin W: White, Not of Hispanic Origin H: Hispanic A: Asian or Pacific Islander E: American Indian or Alaskan Native U: Unknown O: Other

**CITIZENSHIP INFORMATION**

Are you a U.S. citizen?  Yes  No

If No, do you have satisfactory immigration status?  Yes  No Include alien number, date of status, and date entered country, if applicable.

Alien Number	Date of Status (DOS)	Date Entered Country (DEC)
--------------	----------------------	----------------------------

Is your spouse a U.S. citizen?  Yes  No

If No, does your spouse have satisfactory immigration status?  Yes  No Include alien number, date of status, and date entered country, if applicable.

Alien Number	Date of Status (DOS)	Date Entered Country (DEC)
--------------	----------------------	----------------------------

**MEDICARE INFORMATION**

Applicant's Medicare Number (From Red and Blue Medicare Card)	
Do you have Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date
Do you have Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date
Spouse's Medicare Number (From Red and Blue Medicare Card)	
Does your spouse have Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date
Does your spouse have Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date

Would you like us to consider providing retroactive reimbursement of your Medicare premium?  Yes  No

Do you or your spouse pay any health insurance premiums other than Medicare?  Yes  No

Who?	Monthly Amount \$
------	-------------------

Do you or your spouse pay child/spousal support?  Yes  No

Who?	Monthly Amount \$
------	-------------------

Do you or your spouse receive payments from or are named beneficiary of a trust?  Yes  No

Who?	Value \$
------	----------

**INCOME**

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc. If necessary, attach an extra sheet to list all sources of income.

Name of Applicant, Spouse, or Child Under 18	Who Provides the Money? (Name/Source of Income)	What Amount?	How Often? (Weekly, Every Two Weeks, Monthly, Other)

Do you want to receive notices in:  English Only  Spanish and English

**CONSENT**

I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for Medicaid. If additional information is requested, I will provide it.

**SIGNATURES**

Applicant/Representative Signature	Date
Spouse Signature	Date
Representative Address	
City	State
Phone Number	Zip Code
Relationship	

## NOTES:

## PLAN FINDER

### Quick Facts

- Plan Finder does not include every drug that Medicare covers. The Plan Finder drug list is updated on a regular basis. If you can't find your drug, contact your plan to find out if it is covered. Remember that Medicare drug plans may choose to cover some or all of the drugs that Medicare covers. Plans may also cover drugs that aren't listed. Plan Finder doesn't show pricing for over-the-counter drugs or diabetic supplies (e.g. test strips, lancets, needles), so these items can't be added to your drug list.
- The plan finder does not have the capacity to let you enter more than 25 drugs. If you need to enter more than 25 drugs, you should contact 1-800-Medicare. The Customer Service Representatives may record up to 50 drugs.
- You can always perform a General Search using only your zip code. You will then be asked to enter other information for a more accurate search, such as the list of your drugs and your favorite pharmacies. For a more Personalized Search, at minimum you will need to have: Zip Code; Medicare Number; Last Name; Effective Date for your plan; Date of Birth
- In Step 1 of 4 of the search, an option appears under this question: "Do you get help from Medicare or your state to pay your Medicare prescription drug costs?" This allows you to indicate that they are receiving help from Medicaid. In Step 4 of 4 (Refine Your Plan Results) of the search, expand the "Select Special Needs Plans" option on the left side of the screen. Check "plans for people who are eligible for both Medicare and Medicaid" and update the Refine Your Plan Results page. As you proceed to the Plan Results page, you will see some plans titled "Medicare-Medicaid Plan" as well as other plans you may want to look at, including special needs plans.
- Several factors affect drug prices: drug dosage and quantity selected, pharmacy selection, the subsidy level of the beneficiary, as well as the actual timing for drug purchases. Plan Finder provides estimated pricing for what you will pay at your pharmacy. If the dosages and frequencies you use on Plan Finder are different than what you've been prescribed, you may go into a coverage phase that may influence the cost share you pay.
- Generally, plans can negotiate more competitive pricing from mail order pharmacies, but this may not always be the case. To find the most cost-effective way to buy your drugs, refer to the Drug Benefit Summary popup you'll find on the Plan Comparison and Details pages, or you can contact the plan.
- A network pharmacy is a pharmacy that a plan contracts with to offer drugs at a certain price. Some plans distinguish network pharmacies as preferred over other pharmacies, because they can offer better drug prices or better benefits.

- The plan finder does not calculate penalties. It is the responsibility of the plan to determine penalties when processing enrollments.
- Due to HIPAA regulations, personal information such as HICN, Effective Date, Last Name, DOB and Zip Code will be erased when the back button is used during a personalized search.
- If the 'Confirmation' page displays with a 14-digit confirmation number, your enrollment has been saved. You should write down the confirmation number or print the confirmation page so that you can refer to it later, or when you want to call the plan or 1-800-MEDICARE. You can also use the "Email Your Confirmation" button to send an email containing all the information on the Confirmation page

**Technical Problems:** First contact NYSOFA HIICAP Staff at:

Heather Leddick – [Heather.Leddick@aging.ny.gov](mailto:Heather.Leddick@aging.ny.gov) 518-474-2401  
 Brenda LaMere – [Brenda.LaMere@aging.ny.gov](mailto:Brenda.LaMere@aging.ny.gov) 518-474-6085

Planfinder technical issues must be completed on a Planfinder Intake Form (see page 63. This form will be sent to the Planfinder Network Team.

## PUBLICATIONS

The following instructions are set up so you can create an account and order CMS Publications:

- 1) To create an account, go to <http://productordering.cms.hhs.gov/>.
- 2) Register.
- 3) When filling out your information, be sure to explain in the text provided why you need access to this publication site (i.e., County SHIP Coordinator).
- 4) An email will be sent to you once CMS approves your request.
- 5) Once approved, you will have access to order CMS publications. Quantity limits are pre-determined for certain publications. CMS does not ship to PO Boxes.

### Medicare Plan Finder Intake Form

To better assist you, we would like to collect the following information. The fields indicated by the \* are required fields. If you have an inquiry about specific plans or pricing, please provide complete answers to all fields.

<b>1.</b>	<b>Date of Reported Problem: *</b>	<b>2.</b>	<b>Time of Reported Problem:*</b>		
<b>3.</b>	<b>Which search did you use:*</b>	<input type="checkbox"/>	General Search	<input type="checkbox"/>	Personalized Search
<b>4.</b>	<b>Zip Code*:</b>				
<b>5.</b>	<b>Which step are you reporting: *</b>				
	Enter Information				
	Enter Your Drugs				
	Select Your Pharmacies				
	Refine Your Results Page				
	Your Plan Results				
	Your Plan Comparison - (Overview, Plan Benefit, Drug Costs and Coverage, or Plan				
	Your Plan Details - (Overview, Plan Benefit, Drug Costs and Coverage, or Plan Ratings?)				
<b>6.</b>	<b>Subsidy Level:</b>				
	Full				
	Partial				
	Not Applicable				
<b>7.</b>	<b>Drug List ID:</b>				
<b>8.</b>	<b>Password date:</b>				
<b>9.</b>	<b>Specify the name, dosage and quantities of the drug(s) in question:</b>				
	<b>Drug Name</b>	<b>Dosage</b>	<b>Drug Quantity</b>	<b>Frequency</b>	
<b>10.</b>	<b>Provide Plan Name(s) or Contract ID(s) and Plan ID(s) (format: S1234-001 or H1234-001):</b>				
	<b>Plan Name(s)</b>	<b>Contract ID(s)</b>	<b>Plan ID(s)</b>		
<b>11.</b>	<b>Web page(s) title:*</b>				
<b>12.</b>	<b>Server Number (located in the navy-blue Medicare banner at the bottom left corner of</b>				
<b>13.</b>	<b>Provide detailed description of the problem: *</b>				

## NOTES:

## REPORTING

The following provides an overview of the four (4) required reports, and their reporting periods in the new STARS system:

- 1) **BENEFICIARY CONTACT FORM** - Records all client contacts. Contacts can be made over the phone, in person, at the office or in a home, via postal mail, email or a fax transmittal.
  
- 2) **MEDIA OUTREACH & EDUCATION FORM** – Used to report all media outreach and education such as billboards, email blasts, print ads/ articles, radio television and others activities.
  
- 3) **GROUP OUTREACH & EDUCATION FORM** - Used to report interactive presentations, booth exhibits and enrollment events. GOE data count towards SHIP Performance Measure #2 Number of Attendees.

Dates of contacts, media events, and group outreach & education.	Data Due Date:
April	May 31 <sup>st</sup>
May	June 30 <sup>th</sup>
June	July 31 <sup>st</sup>
July	August 31 <sup>st</sup>
August	September 30 <sup>th</sup>
September	October 31 <sup>st</sup>
October	November 30 <sup>th</sup>
November	December 31 <sup>st</sup>
December	January 31 <sup>st</sup>
January	February 28 <sup>th</sup>
February	March 31 <sup>st</sup>
March	April 30 <sup>th</sup>

4) **Resource Report** - Resource Report information will now be captured directly from data reported into the new STARS system. The Team Member Profile captures the various demographic information needed such as the number of paid and in-kind staff, volunteers, program support personnel, program managers, age, gender, ethnicity, years of program experience and secondary language capacity. The number of hours allocated to the HIICAP program will be captured by the Activity Form and through the reported time spent on beneficiary contacts and outreach activities.

**Questions?** Contact Helen Fang at 518-473-3002 or [Helen.Fang@aging.ny.gov](mailto:Helen.Fang@aging.ny.gov)

<b>BENEFICIARY CONTACT FORM</b>			
<b>* Items marked with asterisk (*) indicate required fields</b>			
<b>MIPPA Contact *:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Send to SMP:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>SIRS eFile ID:</b> (*required if sending record to SMP)	
<b>Counselor Information *</b>			
Session Conducted By*: _____	ZIP Code of Session Location * : _____	State of Session Location *: _____	
Partner Organization Affiliation*: _____	County of Session Location *: _____		
<b>Beneficiary &amp; Representative Name and Contact Information</b>			
Beneficiary First Name: _____	Representative First Name: _____		
Beneficiary Last Name: _____	Representative Last Name: _____		
Beneficiary Phone: (____) - _____ - _____	Representative Phone: (____) - _____ - _____		
Beneficiary Email: _____	Representative Email: _____		
<b>Beneficiary Residence *</b>			
State of Bene Res. * : _____	County of Bene Res. * : _____		
Zip Code of Bene Res. * : _____			
Date of Contact *:			
<b>How Did Beneficiary Learn About SHIP * (select only one):</b>			
<input type="checkbox"/> CMS Outreach	<input type="checkbox"/> Previous Contact	<input type="checkbox"/> SHIP TA Center	<input type="checkbox"/> Other
<input type="checkbox"/> Congressional Office	<input type="checkbox"/> SHIP Mailings	<input type="checkbox"/> SSA	<input type="checkbox"/> Not Collected
<input type="checkbox"/> Friend or Relative	<input type="checkbox"/> SHIP Media	<input type="checkbox"/> State Medicaid Agency	
<input type="checkbox"/> Health/Drug Plan	<input type="checkbox"/> SHIP Presentation	<input type="checkbox"/> 1-800 Medicare	
<input type="checkbox"/> Partner Agency	<input type="checkbox"/> State SHIP Website		
<b>Method of Contact * (select only one):</b>	<b>Beneficiary Age Group * (select only one):</b>	<b>Beneficiary Gender * (select only one):</b>	

<input type="checkbox"/> Phone Call	<input type="checkbox"/> Face to Face at	<input type="checkbox"/> Face to Face at Bene Home/ Facility	<input type="checkbox"/> 64 or Younger	<input type="checkbox"/> 85 or Older	<input type="checkbox"/> Female
<input type="checkbox"/> Email	<input type="checkbox"/> Session Location/ Event Site		<input type="checkbox"/> 65 – 74	<input type="checkbox"/> Not Collected	<input type="checkbox"/> Male
<input type="checkbox"/> Web-based			<input type="checkbox"/> 75 – 84		<input type="checkbox"/> Other
<input type="checkbox"/> Postal Mail or Fax					<input type="checkbox"/> Not Collected
<b>Beneficiary Race * (multiple selections allowed):</b>			<b>Beneficiary Language *:</b>		
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	English is Beneficiary's Primary Language <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Asian	<input type="checkbox"/> Other	<input type="checkbox"/> Not Collected	<b>Receiving or Applying for Social Security Disability or Medicare Disability * (select only one):</b>		
<input type="checkbox"/> Black or African American			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Hispanic or Latino			<b>Beneficiary Monthly Income * (select only one):</b>		
<input type="checkbox"/> Below 150% FPL	<input type="checkbox"/> Not Collected		<b>Beneficiary Assets * (select only one):</b>		
<input type="checkbox"/> At or Above 150% FPL			<input type="checkbox"/> Below LIS Asset Limits	<input type="checkbox"/> Not Collected	
			<input type="checkbox"/> Above LIS Asset Limits		
<b>Topics Discussed * (At least one Topic Discussed selection is required. Multiple selections allowed)</b>					
<b>Original Medicare (Parts A &amp; B)</b>	<input type="checkbox"/> Appeals/Grievances	<input type="checkbox"/> Benefit Explanation	<b>Medigap and Medicare Select</b>	<input type="checkbox"/> Benefit Explanation	<input type="checkbox"/> Claims/Billing
	<input type="checkbox"/> Claims/Billing	<input type="checkbox"/> Coordination of Benefits Eligibility		<input type="checkbox"/> Eligibility/Screening Fraud and Abuse	<input type="checkbox"/> Marketing/Sales Complaints & Issues
	<input type="checkbox"/> Enrollment/Disenrollment	<input type="checkbox"/> Fraud and Abuse		<input type="checkbox"/> Plan Non-Renewal	<input type="checkbox"/> Plans Comparison
	<input type="checkbox"/> QIO/Quality of Care				
<b>Topics Discussed (multiple selections allowed) (continued from p.1)*</b>					
<b>Medicare Advantage (MA and MA-PD)</b>			<b>Medicaid</b>		
<input type="checkbox"/> Appeals/Grievances	<input type="checkbox"/> Benefit Explanation	<input type="checkbox"/> Claims/Billing	<input type="checkbox"/> Application Submission	<input type="checkbox"/> Benefit Explanation	<input type="checkbox"/> Claims/Billing
<input type="checkbox"/> Disenrollment	<input type="checkbox"/> Eligibility/Screening	<input type="checkbox"/> Enrollment	<input type="checkbox"/> Fraud and Abuse	<input type="checkbox"/> Medicaid Application Assistance	<input type="checkbox"/> Medicare Buy-in Coordination
<input type="checkbox"/> Fraud and Abuse	<input type="checkbox"/> Marketing/Sales Complaints & Issues	<input type="checkbox"/> Plan Non-Renewal	<input type="checkbox"/> Medicaid Managed Care	<input type="checkbox"/> MSP Application Assistance	<input type="checkbox"/> Recertification
<input type="checkbox"/> Plans Comparison	<input type="checkbox"/> QIO/Quality of Care		<input type="checkbox"/> Other		
<b>Medicare Part D</b>	<input type="checkbox"/> Appeals/Grievances	<input type="checkbox"/> Benefit Explanation	<b>Other Insurance</b>		
<input type="checkbox"/> Claims/Billing	<input type="checkbox"/> Disenrollment	<input type="checkbox"/> Eligibility/Screening	<input type="checkbox"/> Active Employer Health Benefits		

- Enrollment
- Fraud and Abuse
- Marketing/Sales Complaints & Issues
- Plan Non-Renewal
- Plans Comparison

- COBRA
- Indian Health Services
- Long Term Care (LTC) Insurance
- LTC Partnership
- Other Health Insurance
- Retiree Employer Health Benefits
- Tricare For Life Health Benefits
- Tricare Health Benefits
- VA/Veterans Health Benefits
- Other

**Part D Low Income Subsidy (LIS/Extra Help)**

- Appeals/Grievances
- Application Assistance
- Application Submission
- Benefit Explanation
- Claims/Billing
- Eligibility/Screening
- LI NET/BAE

**Other Prescription Assistance**

- Manufacturer Programs
- Military Drug Benefits
- State Pharmaceutical Assistance Programs
- Union/Employer Plan
- Other

**Additional Topic Details**

- Ambulance
- Dental/Vision/Hearing
- DMEPOS
- Duals Demonstration
- Home Health Care
- Hospice
- Hospital
- New Medicare Card
- New to Medicare
- Preventive Benefits
- Skilled Nursing Facility

**Total Time Spent on This Contact \***

\_\_\_ Hours \_\_\_ Minutes

**Status \***

In Progress     Completed

**Special Use Fields**

Original PDP/MA-PD Cost: \_\_\_\_\_

Field 3: \_\_\_\_\_

New PDP/MA-PD Cost: \_\_\_\_\_

Field 4: \_\_\_\_\_

Field 5: \_\_\_\_\_

**Notes**

**GROUP OUTREACH & EDUCATION FORM**

**\* Items marked with asterisk (\*) indicate required fields**

<b>MIPPA Event *:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Send to SMP:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>SIRS eFile ID:</b> (*required if sending record to SMP)		_____

**Event Details \***

Session Conducted By *: _____	Partner Organization Affiliation* : _____
Total Time Spent on Event *: _____ Hours _____ Minutes	Title of Interaction *: _____
Number of Attendees * : _____	Type of Event * (select only one): <input type="checkbox"/> Booth/Exhibit (Health Fair, Senior Fair or Community Event) <input type="checkbox"/> Enrollment Event <input type="checkbox"/> Interactive Presentation to Public (In-Person, Video Conference, Web-based Event, Teleconference)
Start Date of Activity * : _____ End Date of Activity : _____	

**Event Location \***

State of Event \* : \_\_\_\_\_ Zip Code of Event \* : \_\_\_\_\_

County of Event \* : \_\_\_\_\_

**Event Contact Information**

Event Contact First Name: _____	Event Contact Phone: _____
Event Contact Last Name: _____	Event Contact Email: _____

**Intended Audience \* (multiple selections allowed):**

<input type="checkbox"/> Beneficiaries	<input type="checkbox"/> Limited-English Proficiency	<input type="checkbox"/> People with Disabilities
<input type="checkbox"/> Employer-Related Groups	<input type="checkbox"/> Medicare Pre-Enrollees	<input type="checkbox"/> Rural Beneficiaries
<input type="checkbox"/> Family Members/Caregivers	<input type="checkbox"/> Partner Organizations	<input type="checkbox"/> Other

**Target Beneficiary Group \* (multiple selections allowed):**

<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Rural
<input type="checkbox"/> Asian	<input type="checkbox"/> Languages Other Than English	<input type="checkbox"/> N/A
		<input type="checkbox"/> Not Collected





- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Beneficiaries             | <input type="checkbox"/> Limited-English Proficiency | <input type="checkbox"/> People with Disabilities |
| <input type="checkbox"/> Employer-Related Groups   | <input type="checkbox"/> Medicare Pre-Enrollees      | <input type="checkbox"/> Rural Beneficiaries      |
| <input type="checkbox"/> Family Members/Caregivers | <input type="checkbox"/> Partner Organizations       | <input type="checkbox"/> Other                    |

**Target Beneficiary Group \* (multiple selections allowed):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Hispanic/Latino                           | <input type="checkbox"/> Rural         |
| <input type="checkbox"/> Asian                             | <input type="checkbox"/> Languages Other Than English              | <input type="checkbox"/> N/A           |
| <input type="checkbox"/> Black or African American         | <input type="checkbox"/> Low Income                                | <input type="checkbox"/> Not Collected |
| <input type="checkbox"/> Disabled                          | <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> Other         |

**Topics Discussed \* (multiple selections allowed):**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Duals Demonstration              | <input type="checkbox"/> Medicare Fraud and Abuse          | <input type="checkbox"/> Other Prescription Drug Coverage |
| <input type="checkbox"/> Extra Help/LIS                   | <input type="checkbox"/> Medicare Part D                   | <input type="checkbox"/> Partnership Recruitment          |
| <input type="checkbox"/> General SHIP Program Information | <input type="checkbox"/> Medicare Savings Program          | <input type="checkbox"/> Preventive Services              |
| <input type="checkbox"/> Long-Term Care Insurance         | <input type="checkbox"/> Medigap or Supplemental Insurance | <input type="checkbox"/> Volunteer Recruitment            |
| <input type="checkbox"/> Medicaid                         | <input type="checkbox"/> Original Medicare (Parts A and B) | <input type="checkbox"/> Other                            |
| <input type="checkbox"/> Medicare Advantage               |  |   |

**Special Use Fields**

Field 1: \_\_\_\_\_

Field 2: \_\_\_\_\_

Field 3: \_\_\_\_\_

Field 4: \_\_\_\_\_

Field 5: \_\_\_\_\_

**Notes**

## UNINSURED

### ⚙ Helpful Tip!

- Some pharmacies waive or reduce co-pays for low-income individuals.
- Some hospitals offer programs and services to assist low-income individuals.
- Community Health Centers accept sliding scale payment - based on income.
- Free Rx samples may be available at the Doctor's Office!

**AIDS Drug Assistance Program (ADAP)** – To qualify, you must be low-income, uninsured or underinsured with HIV/AIDS. In State- 1-800-542-2437; out of State - (518) 459-1641 or visit: <https://www.health.ny.gov/diseases/aids/general/resources/adap/> .

**Caring Voice Coalition (CVC)** - To qualify for financial assistance through CVC, you must be diagnosed with one of the following conditions: pulmonary hypertension, idiopathic pulmonary fibrosis, or Alpha 1. CVC may be able to help pay for some of the costs associated with prescription drugs for certain medical conditions. To apply, call 1-888-267-1440 or visit: <http://www.caringvoice.org/2018-financial-assistance-applications/> .

**Community Health Advocates (CHA)** – This program is similar to HIICAP. They are a great resource if you would like to refer a person, especially for those who do not qualify for Medicare! Contact [cha@cssny.org](mailto:cha@cssny.org) or 1-888-614-5400 or visit [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org) .

**Federal Employee Health Benefit Program (FEHBP)** – FEHBP provides assistance to Federal employees, retirees, and covered family members. FEHBP offers low cost Rx with participating pharmacies only. To find out more information, call 1-888-767-6738 or visit: <https://www.opm.gov/retirement-services/>, <https://www.opm.gov/healthcare-insurance/healthcare/> or <https://www.opm.gov/healthcare-insurance/Guide-Me/Retirees-Survivors/#url=Health> .

**GoodRx** – Save up to 80% on prescription drugs at most U.S. pharmacies, 1-888-277-3911 or visit <https://www.goodrx.com/>.

**Great Expressions Dental Centers (formerly American Dental Centers)** – This is a membership group – annual fee includes two dental exams, two treatment plans, x-rays up to full series (once a year) and cleaning - prophylaxis (one per year). Other services are discounted to members. Must use their dental offices. Family rates are also available. 1-888-764-5380 or <https://www.greatexpressions.com/special-offers/spp-home> .

**Health Economics Group, Inc.'s Dental Network Card Program** – Offers referral services to dentists in your area who are will to accept lower fees as full payment for people without dental insurance. To find out more information, call 1-800-666-6690 ext. 505, 585-241-9500 ext. 505 or <http://www.heginc.com/dentemax-NYSAC.html> .

**The HealthWell Foundation** – Helps pay your drug copays if you have insurance or your monthly premiums. You must be diagnosed with Acute Porphyria, Anemia associated

with Chronic Renal Insufficiency/Chronic Renal Failure, Chemotherapy Induced Anemia/Chemotherapy Induced Neutropenie, and other systems. To find out if you qualify, call 1-800-675-8416 or visit: <https://www.healthwellfoundation.org/>.

**LawHelp.Org/NY** – Helps low income New Yorkers solve legal problems such consumer debt, disability, housing, immigration, medical debt and taxes. More information can be found at: <https://www.lawhelpny.org/> .

**My Good Days (formerly Chronic Disease Fund)** – Offers two programs for people who do, and do not have, insurance. An individual must be diagnosed with one of the following conditions: Adult Growth Hormone Deficiency, Ankylosing Spondylitis, Asthma, Pediatric Growth Hormone Deficiency, Myelodysplastic Syndrome (MDS), Psoriasis, Psoriatic Arthritis, or Rheumatoid Arthritis. To find out more information, call 1-877-968-7233 or visit: <https://www.mygooddays.org/for-patients/> .

**New York State Exchange (Marketplace)** - Quickly compare health plan options and apply for assistance that could lower the cost of health insurance coverage for working uninsured, uninsured sole proprietors and individual plans. You may also qualify for health care coverage from Medicaid or Child Health Plus through the Marketplace. To find out more information, call 1-855-355-5777 or visit: <http://www.nystateofhealth.ny.gov> .

**National Organization for Rare Disorders (NORD)** – Medication assistance program that helps people obtain Rx they could not originally afford or that are not yet on the market. Over 1,100 rare diseases are listed on NORD's webs site. To apply, call (800) 999-6673 or visit: <https://rarediseases.org/>

**NYS Department of Health** - New York State Board of Pharmacy publishes an annual list of the 150 most frequently prescribed drugs, in the most common quantities. The NYS Dept. of Health collects retail price information on these drugs from pharmacies that participate in the Medicaid program. This site <https://apps.health.ny.gov/pdpw/SearchDrugs/Home.action> allows you to search for a specific drug from the most frequently prescribed drug list.

**New York Rx Card** – This option may save a person over 50% on an expensive drug. No age or income limits. For more information, please visit: <https://www.newyorkrxcard.com/> or call 1-800-931-2297.

**Modest Needs** - is a Charity Organization that connects people with grantors, or see if any religious/community organizations may offer assistance. The program helps hard-working, low-income household to afford short-term emergency expenses. For more information, please visit: <https://www.modestneeds.org> or call 1-844-667-3776.

**Partnership for Prescription Assistance** - This group brings together America's pharmaceutical companies, doctors, and health care providers, patient advocacy organizations and community groups to help qualifying patients who lack prescription

coverage get the medicines they need through the public or private program, Through this site, the Partnership for Prescription Assistance offers a single point of access to more than 475 public and private patient assistance programs, including more than 180 programs offered by pharmaceutical companies. To find out more information, call 1-888-04PPA-NOW (1-888-477-2669) or visit: <https://www.pparx.org/>.

**Patient Advocate Foundation Co-Pay Relief** - Provides direct co-payment assistance for pharmaceutical products to insured Americans who financially and medically qualify. You must be diagnosed with and taking medication(s) for one of the following conditions: diabetes, breast cancer, colon cancer, kidney cancer, lung cancer, lymphoma, prostate cancer, sarcoma, macular degeneration, other medical problems caused by your cancer treatment. To find out more information, call 1-866-512-3861 or visit: [www.copays.org](http://www.copays.org).

**Patient Services Incorporated (PSI)** - Helps people with specific conditions (see website for conditions), regardless of income. PSI offers premium assistance for COBRA, high-risk insurance pools and private health insurance. To apply, call 1-800-366-7741 or visit: <https://www.patientservicesinc.org/>

**Pfizer Medicines** – Pfizer is a patient assistance program that makes locating services more accessible. Through their Program Finder tool, uninsured and underinsured patients who qualify are able to search for medicines free of charge or at a savings and receive reimbursement services. To find out more information, call 1-844-989-7284 or visit <http://www.pfizerxpathways.com/>.

**Pharmaceutical Company Patient Assistance Programs (PhRMA)** – Usually low income with no other Rx coverage. Free or heavily discounted Rx for limited duration (often 90 days). You must have internet access to search. You can search by drug name, company or class. For a directory of programs, contact 1-800-931-8691 or visit: [www.rxassist.org](http://www.rxassist.org), <https://www.myrxadvocate.com/>, <http://www.xubex.com/>, <http://www.needymeds.org/>

**Rx Outreach** – No age limit. You must have income less than \$34,470 (\$46,530 for married couples). No enrollment fees. To find out more information, call 1-800-769-3880, 1-888-796-1234 or <http://rxoutreach.org/>.

**TRICARE** – is a program for military retirees who have served at least 20 years. You must be registered with Defense Enrollment. No enrollment fees and low-cost Rx. To find out more information, call TRICARE North (Health Net) for NYS Residents at 1-877-TRICARE or 1-877-874-2273 or for Rx benefits contact Express Scripts, Inc. at 1-877-363-1303.

**VA Health Benefits Service Center** – Veteran must have been honorably discharged from the military. Must enroll with VA and be seen by VA doctor. To find out more information, call 1-877-222-8387 or visit <https://www.vets.gov/health-care/about-va-health-care/>.

**Vision Services (Low Cost):**

New York State Commission for the Blind – Information on programs for older adults: 1-866-871-3000 or visit <http://ocfs.ny.gov/main/cb/> .

Lighthouse International – worldwide organization dedicated to overcoming vision impairment through rehabilitation, education, research and advocacy. 1-800-284-4422, [www.lighthouseguild.org](http://www.lighthouseguild.org)

Eyecare America – provides eye exams and up to one year of care to US citizens and legal residents within the Continental U.S., Hawaii and Puerto Rico through volunteer ophthalmologists at **no out-of-pocket cost to those who qualify**. 1-877-887-6327, <https://www.aaopt.org/eyecare-america>.

New Eyes for the Needy – New Eyes for the Needy purchases new prescription eyeglasses for poor children and adults living in the United States. 1-973-376-4903, [www.new-eyes.org](http://www.new-eyes.org).

**EPIC Territory Designation**  
**EPIC Outreach General Mailbox: [NYSEPICOutreach@magellanhealth.com](mailto:NYSEPICOutreach@magellanhealth.com)**

**Mark McLaughlin – 581-801-5437**  
**[Mclaughlinm@magellanhealth.com](mailto:Mclaughlinm@magellanhealth.com)**

<b>North Country</b>	Clinton	Lewis
	Essex	St. Lawrence
	Franklin	Warren
	Hamilton	Washington
	Jefferson	
<b>Capital District and Central New York</b>		
	Albany	Otsego
	Columbia	Putnam
	Cortland	Rensselaer
	Delaware	Saratoga
	Dutchess	Schenectady
	Fulton	Schoharie
	Greene	Sullivan
	Herkimer	Ulster
	Montgomery	
Orange		

**Gabrielle Dotterweich – 716-367-0952**  
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<b>Central New York and Southern Tier</b>	Broome	
	Chenango	
	Madison	
	Oneida	
	Onondaga	
	Oswego	
<b>Western New York</b>	Allegany	Ontario
	Cattaraugus	Orleans
	Cayuga	Schuyler
	Chautauqua	Seneca
	Chemung	Steuben
	Erie	Tioga
	Genesee	Tompkins
	Livingston	Wayne
	Monroe	Wyoming
Niagara	Yates	

**Marie E Kernizan – 518-801-5427**  
**[Kernizanm@magellenhealth.com](mailto:Kernizanm@magellenhealth.com)**

<b>Downstate</b>	Bronx	Richmond
	Kings	Suffolk
	Nassau	Westchester
	New York	
	Queens	
	Rockland	

**NOTES:**

## HIICAP COORDINATORS LIST

Area Agency on Aging	Subcontractor
<b>ALBANY</b>	
Vacant Albany County Department for Aging 162 Washington Avenue Albany, NY 12210 518-447-7195      Fax: 518-447-7188	Sallie Fuller, HIICAP Coordinator Senior Services of Albany 10 Cayuga Plaza Cohoes, NY 12206 <b>HIICAP Helpline: 518-447-7177</b> Email: <a href="mailto:sfuller@seniorservicesofalbany.com">sfuller@seniorservicesofalbany.com</a>
<b>ALLEGANY</b>	
Anita Mattison, Coordinator Allegany County Office for the Aging 6085 State Route 19N Belmont, NY 14813 <b>Helpline 585-268-9390</b> Fax: 585-268-9657 Email: <a href="mailto:MattisA@alleganyco.com">MattisA@alleganyco.com</a>	
<b>BROOME</b>	
Jaime Kelly Broome County Office for the Aging Governmental Plaza, 4th Floor PO Box 1766 Binghamton, NY 13902-1766 607-778-2922      Fax: 607-778-2316 Email: <a href="mailto:jkelly2@co.broome.ny.us">jkelly2@co.broome.ny.us</a>	Jane Talbot, Coordinator Action for Older Persons, Inc. 200 Plaza Drive Suite B Vestal, NY 13850 <b>HIICAP Helpline 607-722-1251</b> Fax: 607-722-1293 Email: <a href="mailto:Jtalbot@actionforolderpersons.org">Jtalbot@actionforolderpersons.org</a>
<b>CATTARAUGUS</b>	
Anne Parks, Coordinator Cattaraugus County Dept. for the Aging One Leo Moss Drive, Suite 7610 Olean, NY 14760 <b>Helpline 716-373-8032 Ext.3206</b> Fax: 716-701-3730 Email: <a href="mailto:ALParks@cattco.org">ALParks@cattco.org</a>	
<b>CAYUGA</b>	
Nicole Sedorus, Coordinator Cayuga County Office for the Aging County 160 Genesee Street Auburn, NY 13021-3483 <b>Helpline 315-253-1226</b> Fax: 315-253-1151 Email: <a href="mailto:nsedorus@cayugacounty.us">nsedorus@cayugacounty.us</a>	
<b>CHAUTAUQUA</b>	
Christine Cheronis, Coordinator Chautauqua County Office for the Aging 610 West Third Street Jamestown, NY 14701 <b>Helpline 716-753-4471</b> Fax: 716-753-4477 Email: <a href="mailto:CheroniC@co.chautauqua.ny.us">CheroniC@co.chautauqua.ny.us</a>	

<b>CHEMUNG</b>	
<p>Kim Sills, Coordinator Chemung County Department of Aging &amp; Long Term Care 425 Pennsylvania Avenue, PO Box 588 Elmira, NY 14902-0588 <b>Helpline 607-737-5520</b> Fax: 607-737-5521 Email: <a href="mailto:ksills@co.chemung.ny.us">ksills@co.chemung.ny.us</a></p>	
<b>CHENANGO</b>	
<p>Jane Muserilli, Coordinator Chenango County Area Agency on Aging 5 Court Street, County Office Building Norwich, NY 13815-1794 <b>Helpline 607-337-1770</b> Fax: 607-337-1749 Email: <a href="mailto:Janem@co.chenango.ny.us">Janem@co.chenango.ny.us</a></p>	
<b>CLINTON</b>	
<p>Marisa Pers, Coordinator Clinton County Office for the Aging 135 Margaret Street, Suite 105 Plattsburgh, NY 12901-2966 <b>Helpline 518-565-4621</b> Fax: 518-565-4812 Email: <a href="mailto:marisa.pers@clintoncountygov.com">marisa.pers@clintoncountygov.com</a></p>	
<b>COLUMBIA</b>	
<p>Kim Martens, HIICAP Coordinator Columbia County Office for the Aging 325 Columbia Street Hudson, NY 12534 <b>Helpline 518-828-0069</b> Fax: 518-822-0010 Email: <a href="mailto:kim.martens@columbiacountyny.com">kim.martens@columbiacountyny.com</a></p>	
<b>CORTLAND</b>	
<p>Cindy Stout, Coordinator Cortland County Office for the Aging 60 Central Avenue Cortland, NY 13045-5590 <b>Helpline 607-753-5181</b> Fax: 607-758-5528 <a href="mailto:cstout@cortland-co.org">cstout@cortland-co.org</a></p>	
<b>DELAWARE</b>	
<p>Vacant, Coordinator Delaware County Office for the Aging 97 Main Street, Suite 2 Delhi, NY 13753 <b>Helpline 607-832-5750</b> Fax: 607-832-6050 Email: _____</p>	
<b>DUTCHESS</b>	
<p>Maggie Kwet, Aging Information Services Specialist Dutchess County Office for the Aging 27 High Street 3<sup>rd</sup> Floor Poughkeepsie, NY 12601 <b>Helpline 845-486-2566</b> Fax: 845-486-2571 Email: <a href="mailto:mkwet@dutchessny.gov">mkwet@dutchessny.gov</a></p>	

<b>ERIE</b>	
William Daniels, Coordinator Erie County Dept. of Senior Services 95 Franklin Street, 13th Floor Buffalo, NY 14202 <b>Helpline 716-858-7883</b> Fax: 716-858-7259 Email: <a href="mailto:danielsw@erie.gov">danielsw@erie.gov</a>	
<b>ESSEX</b>	
Heidi Palmer, HIICAP Coordinator Essex County Office for the Aging 132 Water Street, PO Box 217 Elizabethtown, NY 12932-0217 <b>Helpline 518-873-3695</b> Fax: 518-873-3784 Email: <a href="mailto:hpalmer@co.essex.ny.us">hpalmer@co.essex.ny.us</a>	
<b>FRANKLIN</b>	
Joanne Riccio, HIICAP Coordinator Franklin County Office for the Aging 355 West Main Street, Suite 447 Malone, NY 12953-1826 <b>Helpline 518-481-1532</b> Fax: 518-481-1635 Email: <a href="mailto:jriccio@co.franklin.ny.us">jriccio@co.franklin.ny.us</a>	
<b>FULTON</b>	
Andrea Fettinger, Acting Coordinator Fulton County Office for Aging 19 North William Street Johnstown, NY 12095-2534 <b>Helpline 518-736-5650</b> Fax: 518-762-0698 Email: <a href="mailto:afettinger@co.fulton.ny.us">afettinger@co.fulton.ny.us</a>	
<b>GENESEE</b>	
Kimberly Perl, Coordinator Genesee County Office for the Aging Two Bank Street Batavia, NY 14020-2299 <b>Helpline 585-343-1611</b> Fax: 585-344-8559 Email: <a href="mailto:Kimberly.Pperl@co.genesee.ny.us">Kimberly.Pperl@co.genesee.ny.us</a>	
<b>GREENE</b>	
Connie Bentley, Coordinator Greene County Office for the Aging 411 Main Street Catskill, NY 12414 <b>Helpline 518-719-3555</b> Fax: 518-719-3798 Email: <a href="mailto:cbentley@discovergreene.com">cbentley@discovergreene.com</a>	
<b>HERKIMER</b>	
Kathy Fox, Director Herkimer County Office for the Aging 109 Mary Street, Suite 1101 Herkimer, NY 13350-2924 315-867-1121      Fax: 315-867-1448 Email: <a href="mailto:kathyfox@herkimercounty.org">kathyfox@herkimercounty.org</a>	Rae Maxson, Coordinator Catholic Charities of Herkimer County 61 West Street Ilion, NY 13357 <b>HIICAP Helpline 315-894-9917 x236</b> Email: <a href="mailto:maxson@ccherkimer.org">maxson@ccherkimer.org</a>

<b>JEFFERSON</b>	
Matthew Wiley, Coordinator Jefferson County Office for the Aging 175 Arsenal Street, 2nd fl. Watertown, NY 13601-2544 <b>Helpline 315-785-3191</b> Fax: 315-785-5095 Email: <a href="mailto:mwiley@co.jefferson.ny.us">mwiley@co.jefferson.ny.us</a>	
<b>LEWIS</b>	
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<b>LIVINGSTON</b>	
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<b>MADISON</b>	
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<b>MONROE</b>	
Director Monroe County Office for the Aging 435 E. Henrietta Rd. Room 3rd FL, West Faith Wing Rochester, NY 14620 585-753-6280 Fax: 585-753-6281	Ron Brandwein, Coordinator Lifespan 1900 South Clinton Avenue Rochester, NY 14618 <b>Helpline 585-244-8400 x113</b> Fax: 585-244-9114 Email: <a href="mailto:rbrandwein@lifespan-roch.org">rbrandwein@lifespan-roch.org</a>
<b>MONTGOMERY</b>	
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<b>NASSAU</b>	
Kathleen Foster Nassau County Dept. of Senior Citizen Affairs 60 Charles Lindbergh Blvd. Ste #260 Uniondale, NY 11553-3691 Phone: 516-227-8915 fax 516-227-8973 <a href="mailto:kathleen.foster@hnsnassaucountyny.us">kathleen.foster@hnsnassaucountyny.us</a>	Pauline Andrews, HIICAP Family and Children's Association 400 Oak Street Garden City, NY 11530 <b>HIICAP Helpline: 516-485-3754</b> Fax: 516-489-8932 Email: <a href="mailto:pandrews@familyandchildrens.org">pandrews@familyandchildrens.org</a>

<b>NEW YORK CITY</b>	
Diane McDaniel-Jackson, J.D. New York City Dept. for the Aging Two Lafayette Street, 9th Floor New York, NY 10007-1392 <b>Helpline – 212-602-4180</b> Email: <a href="mailto:dmcdanie@aging.nyc.gov">dmcdanie@aging.nyc.gov</a>	
<b>NIAGARA</b>	
Susan Christian, Coordinator Niagara County Office for the Aging 111 Main Street, Lockport NY 14094-3396 <b>Helpline 716-438-4023</b> Fax: 716-438-4029 Email: <a href="mailto:Susan.Christian@niagaracounty.com">Susan.Christian@niagaracounty.com</a>	
<b>ONEIDA</b>	
June Hanrahan, Coordinator Oneida County Office for the Aging 120 Airline Street, Suite 201 Oriskany, NY 13424 <b>Helpline 315-798-5456</b> Fax: 315-768-3656 Email: <a href="mailto:jhanrahan@ocgov.net">jhanrahan@ocgov.net</a>	
<b>ONONDAGA</b>	
Myrna Koldin, Coordinator Onondaga County Dept. of Aging & Youth Civic Center - 13th Floor 421 Montgomery Street Syracuse, NY 13202-2911 <b>Helpline 315-435-2362</b> Fax: 315-435-3129 Email: <a href="mailto:mkoldin@ongov.net">mkoldin@ongov.net</a>	
<b>ONTARIO</b>	
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<b>ORANGE</b>	
Erinn Braun, Coordinator Orange County Office for the Aging 18 Seward Avenue Middletown, NY 10940 <b>Helpline &amp; Direct # 845-615-3715</b> Fax: 845-346-1190 Email: <a href="mailto:ebraun@orangecountygov.com">ebraun@orangecountygov.com</a>	
<b>ORLEANS</b>	
Susie Miller, Coordinator Orleans County Office for the Aging 14016 Route 31W Albion, NY 14411-9362 <b>Helpline 585-589-3191</b> Fax: 585-589-3193 Email: <a href="mailto:Susan.Miller@orleanscountyny.com">Susan.Miller@orleanscountyny.com</a>	

<b>OSWEGO</b>	
Bobbi Gill, Coordinator Oswego County Office for the Aging 70 Bunner Street, County Complex Oswego, NY 13126 <b>Helpline 315-349-3485</b> Fax: 315-349-8413 Email: <a href="mailto:rgill@oswegocounty.com">rgill@oswegocounty.com</a>	
<b>OTSEGO</b>	
Many Rogers, Coordinator Otsego County Office for the Aging 140 County Highway 33W, Suite 5 Cooperstown, NY 3326 <b>Helpline 607-547-4232</b> Fax: 607-547-6492 <a href="mailto:rogersm@otsegocounty.com">rogersm@otsegocounty.com</a>	
<b>PUTNAM</b>	
Lynn Hill, Coordinator Putnam County Office for the Aging 110 Old Route 6, Building #1 Carmel, NY 10512-2196 <b>Helpline 845-808-1700</b> Email: <a href="mailto:lynn.hill@putnamcountyny.gov">lynn.hill@putnamcountyny.gov</a>	
<b>RENSELAER</b>	
Sarah Legnard, Coordinator Rensselaer County Unified Family Services Department for the Aging 1600 Seventh Avenue, Troy, NY 12180 <b>Helpline 518-270-2768</b> Fax: 518-270-2737 Email: <a href="mailto:slegnard@rensco.com">slegnard@rensco.com</a>	
<b>ROCKLAND</b>	
Dana Thiesing, Coordinator Rockland County Office for the Aging 50 Sanatorium Road, Building B Pomona, NY 10970-0350 <b>Helpline 845-364-2118</b> Fax: 845-364-2348 Email: <a href="mailto:ThiesinD@co.rockland.ny.us">ThiesinD@co.rockland.ny.us</a>	
<b>SARATOGA</b>	
Mary Rickard, Coordinator Saratoga County Office for the Aging 152 West High Street, Ballston Spa, NY 12020 <b>Helpline 518-884-4910</b> , Fax: 518-884-4104 Email: <a href="mailto:mrickard@saratogacountyny.gov">mrickard@saratogacountyny.gov</a>	

<b>SCHENECTADY</b>	
Cathryn Bern-Smith, Dept. of Senior Services & LTC Schenectady County Senior & LTC Services 107 Nott Terrace Schaffer Heights – 3 <sup>rd</sup> Floor, Suite 305 Schenectady, NY 12308-3170 518-382-8481 x.308 Fax: 518-382-0194 Email: <a href="mailto:Cathryn.Bern-Smith@schenectadycounty.com">Cathryn.Bern-Smith@schenectadycounty.com</a>	Patricia Lacey, Coordinator Catholic Charities Senior & Caregiver Support Services 1473 Erie Blvd. Schenectady, NY 12305 <b>Helpline 518-346-349</b> Fax: 518-372-5686 Email: <a href="mailto:placey@cathcharschdy.org">placey@cathcharschdy.org</a>
<b>SCHOHARIE</b>	
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<b>SCHUYLER</b>	
Kylie Rodrigues, Coordinator Schuyler County Office for the Aging 323 Owego Street, Unit 7 Montour Falls, NY 14865 <b>Helpline 607-535-7108</b> Fax: 607-535-6832 Email: <a href="mailto:krodrigues@co.schuyler.ny.us">krodrigues@co.schuyler.ny.us</a>	
<b>SENECA</b>	
Leeanne Dutcher-Teufel, Coordinator Seneca County Office for the Aging 1 DiPronio Drive Waterloo, NY 13165 <b>Helpline 315-539-1769</b> Fax: 315-539-1923 Email: <a href="mailto:ldutcherteufel@co.seneca.ny.us">ldutcherteufel@co.seneca.ny.us</a>	
<b>SENECA NATION OF INDIANS</b>	
David Hajzus, HIICAP Coordinator 28 Thomas Indian School Drive Irving, New York 14081 <b>Phone: (716) 532-5778 F a x : 716-532-5077</b> Email: <a href="mailto:david.hajzus@sni.org">david.hajzus@sni.org</a>	
<b>ST. LAWRENCE</b>	
Nancy Green, HIICAP Coordinator St. Lawrence County Office for the Aging 80 State Highway 310, Suite 7 Canton, NY 13617-1497 <b>Helpline 315-386-4730</b> Fax: 315-386-8636 Email: <a href="mailto:ngreen@stlawco.org">ngreen@stlawco.org</a>	
<b>ST. REGIS MOHAWK NATION</b>	
Alison Cooke, Coordinator St. Regis Mohawk Tribe Office for the Aging 29 Business Park Rd. Akwesasne, NY 13655 <b>Helpline 518-358-2834</b> Fax: 518-358-3071 Email: <a href="mailto:alison.cooke@srmt-nsn.gov">alison.cooke@srmt-nsn.gov</a>	

<b>STEUBEN</b>	
Lynn Decher, Coordinator Steuben County Office for the Aging 3 East Pulteney Square, Bath, NY 14810-1510 <b>Phone: 607-664-2298 Fax: 607-664-2371</b> Email: <a href="mailto:lynnd@co.steuben.ny.us">lynnd@co.steuben.ny.us</a>	
<b>SUFFOLK</b>	
Maureen Porta, Administrator I Suffolk County Office for the Aging PO Box 6100, H. Lee Dennison Building 100 Veterans Memorial Highway Hauppauge, NY 11788-0099 Phone: 631-853-6651, Fax: 631-853-8225 Email: <a href="mailto:maureen.porta@suffolkcountyny.gov">maureen.porta@suffolkcountyny.gov</a>	Mary Florence Brennan, Coordinator RSVP Suffolk 811 West Jericho Turnpike Suite 103 W Smithtown, NY 11787 <b>Helpline: 631-979-9490 ext. 14</b> Email: <a href="mailto:hiicap@rsvpsuffolk.org">hiicap@rsvpsuffolk.org</a>
<b>SULLIVAN</b>	
Kelly Soller, HIICAP Coordinator Sullivan County Office for the Aging 100 North Street, PO Box 5012 Monticello, NY 12701-1024 <b>Helpline 845-807-0241 Fax: 845-807-0260</b> Email: <a href="mailto:kelly.soller@co.sullivan.ny.us">kelly.soller@co.sullivan.ny.us</a>	
<b>TIOGA</b>	
Danielle Kenyon, HIICAP Coordinator Tioga Opportunities, Inc., Department of Aging Services Countryside Community Center 9 Sheldon Guile Boulevard Owego, NY 13827 <b>Helpline 607-687-4120 x344 Fax: 607-687-4147</b> Email: <a href="mailto:dkenyon@tiogaopp.org">dkenyon@tiogaopp.org</a>	
<b>TOMPKINS</b>	
Lisa Holmes Tompkins County Office for the Aging 320 North Tioga Street Ithaca, NY 14850 607-274-5482 Fax: 607-274-5495 Email: <a href="mailto:lholmes@tompkins-co.org">lholmes@tompkins-co.org</a>	Liza Burger, Coordinator Lifelong 119 West Court Street Ithaca, NY 14850 <b>Helpline 607-273-1511 Fax: 607-272-8060</b> Email: <a href="mailto:LBurger@tclifelong.org">LBurger@tclifelong.org</a>
<b>ULSTER</b>	
Robert Meci, Coordinator Ulster County Office for the Aging 1003 Development Court Kingston, NY 12401 <b>Helpline 845-340-3456 Fax: 845-340-3583</b> Email: <a href="mailto:rmec@co.ulster.ny.us">rmec@co.ulster.ny.us</a>	- -

<b>WARREN</b>	
Hanna Hall, Coordinator Warren/Hamilton Counties Office for the Aging 1340 State Route 9 Lake George, NY 12845 <b>Helpline 518-761-6347</b> Fax: 518-745-7643 Email: <a href="mailto:hallh@co.warren.ny.us">hallh@co.warren.ny.us</a>	
<b>WASHINGTON</b>	
Stephanie Ball, HIICAP Coordinator Washington County Office for the Aging 383 Broadway Street, Suite B10 Fort Edward, NY 12828 <b>Helpline 518-746-2572</b> Fax: 518-746-2418 Email: <a href="mailto:Stephanie.Ball@dfa.state.ny.us">Stephanie.Ball@dfa.state.ny.us</a>	
<b>WAYNE</b>	
Kendra Payne, HIICAP Coordinator Wayne County Department of Aging and Youth 1519 Nye Road, Suite 300 Lyons, NY 14489 <b>Helpline 315-946-5624 F a x : 315-946-5649</b> Email: <a href="mailto:kpayne@co.wayne.ny.us">kpayne@co.wayne.ny.us</a>	
<b>WESTCHESTER</b>	
Dianne Poonai, Coordinator Westchester County Dept. of Senior Programs 9 South First Avenue, 10th Floor Mt. Vernon, NY 10550 <b>Helpline 914-813-6100</b> Fax: 914-813-6399 Email: <a href="mailto:Ddp3@westchestergov.com">Ddp3@westchestergov.com</a>	
<b>WYOMING</b>	
Darla Dabolt, Aging Service Specialist Wyoming County Office for the Aging 8 Perry Avenue, Warsaw, NY 14569 <b>Helpline 585-786-8833</b> Fax: 585-786-8832 Email: <a href="mailto:ddabolt@wyomingco.net">ddabolt@wyomingco.net</a>	
<b>YATES</b>	
Ashley Tillman Coordinator ProAction/Yates County Office for the Aging 417 Liberty Street Suite 1116 Penn, NY 14527 <b>Helpline: 315-536-5515</b> Fax: 315-536-5514 Email: <a href="mailto:tillmana@proactioninc.org">tillmana@proactioninc.org</a>	

## NOTES:

## Medicare Consumer Advocacy Project

The State of New York has funded the following agencies to assist low-income beneficiaries with Part D appeals, exceptions, prior authorization request and other health insurance issues. In addition, they may provide free legal representation.

### **Community Service Society**

**Serves: All of New York State**

633 Third Avenue, 10<sup>th</sup> Floor  
New York, NY 10017

212-614-5353

1-888-614-5353

### **The Legal Aid Society**

**Western NY Serves: All of New York State**

199 Water Street

New York, NY 10038

1-888-500-2455 (upstate)

1-212-577-3575 (NYC area)

### **Medicare Rights Center**

**Serves: All of New York State**

520 Eighth Avenue, North Wing 3<sup>rd</sup> Floor

New York, NY 10018

1-800-333-4114 (consumer)

1-800-480-2060 (HIICAPs)

### **Statewide Senior Action (New York)**

**Serves: All of New York State**

275 State Street

Albany, NY 12210

1-800-333-4374

### **Empire Justice Center**

**Serves: Upstate and Long Island**

119 Washington Avenue

Albany, NY 12210

1-800-635-0355 x112

Empire Subcontracts With



### **Legal Services for the Elderly -**

**Serves: Western New York**

237 Main Street, Suite 1015

Buffalo, NY 14203-2717

716-853-3087

### **New York Legal Assistance Group**

**Serves: NYC Area Only**

450 West 33<sup>rd</sup> Street, 11<sup>th</sup> Floor

New York, NY 10001

212-613-5053

**NOTES:**

## CONTACT NUMBERS FOR PLANS IN NEW YORK STATE

The numbers below have been dedicated to SHIP Counselors to solve complex and escalated issues. **These numbers should not be given to clients.** You may still be required to provide additional information due to HIPAA regulations.

Organization Name	Plan Name	Phone Number
Aetna	Aetna Medicare Rx Plans	866-459-3999
CVS Caremark	CVS Caremark Plans	866-490-2098 x1
Express Scripts	Express Scripts	800-846-4917
Humana	Humana	888-666-2902
Silver script	Silverscript Prescription Plans	888-831-3049
United Health Care	AARP PDP Plans Only	866-507-9609
WellCare Health Plans	All Medicare Advantage and Prescription	866- 675-8574

Don't forget, you can use your SHIP Unique ID with Medicare by calling **1-888-647-6701!**

## NOTES:

<b>SOCIAL SECURITY OFFICES</b> <b>www.socialsecurity.gov</b> <b>Toll-Free                      1-800-772-1213</b>	
Albany County Area Social Security RM 430 Federal Bldg. 11 A Clinton Avenue Albany, NY 12207 Local Number - 1-866-253-9183	Broome County Area Social Security 2 Court St. Suite 300 Binghamton, NY 13901 Local Number 1-866-964-3971
Cattaraugus county Area Social Security 175 N. Union Street Suite 6 Olean, NY 14760 Local Number 1-877-319-5773	Chautauqua County Area Social Security 321 Hazeltine Avenue Jamestown, NY 14701 Local Number 1-877-319-3079
Chemung County Area Social Security Suite 201 100 West Church Street Elmira, NY 14901 Local Number 1-866-964-1715	Clinton County Area Social Security Suite 230 Plattsburgh, NY 12901 Local Number 1-866-296-8271
Columbia County Area Social Security 747 Warren Street Hudson, NY 12534 Local Number 1-877-828-1691	Dutchess County Area Social Security Vassar Main Building - 332 Main Street Poughkeepsie, NY 12601 Local Number 1-877-405-6747
Erie County Area Social Security Suite 100 186 Exchange Street Buffalo, NY 14204 1-800-772-1213	Fulton County Area Social Security 13 N. Arlington Avenue Gloversville, NY 12078 Local Number 1-888-528-9446
Genesee County Area Social Security 571 East Main Street Batavia, NY 14020 Local Number 1-866-931-7103	Jefferson County Area Social Security 156 Bellew Ave. South Watertown, NY 13601 Local Number 1-866-627-6995
Monroe County Area Social Security 100 Chestnut Street Suite 1400 Rochester, NY 14604 1-800-772-1213	Nassau County Area Social Security 84 North Main Street Freeport, NY 11520 1-800-772-1213
New York City Social Security Room 120, 31st Floor 26 Federal Plaza New York, NY 10278 1-800-772-1213	Niagara County Area Social Security 6540 Niagara Falls Blvd. Niagara Falls, NY 14304 Local Number 1-877-480-4992

<p>Oneida County Area Social Security  Federal Building, 10 Broad Street  Utica, NY 13501  Local Number 1-877-405-6750</p>	<p>Ontario County Area Social Security  15 Lewis Street  Geneva, NY 14456  Local Number 1-866-331-7759</p>
<p>Onondaga County Area Social Security  Federal Bldg. 4th Floor  100 S. Clinton Street  Syracuse, NY 13261 1-800-772-1213</p>	<p>Orange County Area Social Security  3 Washington Center, Suite 301  Newburgh, NY 12550  Local Number 1-866-504-4801</p>
<p>Oswego County Area Social Security  17 Fourth Avenue  Oswego, NY 13126  Local Number 1-866-964-7593</p>	<p>Otsego County Area Social Security  31 Main Street - Suite 1  Oneonta, NY 13820  Local Number 1-877-628-6581</p>
<p>Rensselaer County Area Social Security  500 Federal Street - Suite 101  Troy, NY 12180  Local Number 1-866-770-2662</p>	<p>Rockland County Area Social Security  240 West Nyack Road  West Nyack, NY 10994 1-800-772-1213</p>
<p>Schenectady County Area Social Security  1 Broadway Center  Schenectady, NY 12305  Local Number 1-866-964-1296</p>	<p>St. Lawrence County Area Social Security  101 Ford Street  Ogdensburg, NY 13669  Local Number 1-866-572-8369</p>
<p>Steuben County Area Social Security  200 Civic Center Pl.  Corning, NY 14830  Local Number 1-866-591-3665</p>	<p>Suffolk County Area Social Security  75 Oak Street  Patchogue, NY 11772 1-800-772-1213</p>
<p>Sullivan County Area Social Security  60 Jefferson Street, Suite 4  Monticello, NY 12701  Local Number 1-855-794-4728</p>	<p>Tompkins County Area Social Security  127 W. State Street, 2nd Floor  Ithaca, NY 14850  Local Number 1-866-706-8289</p>
<p>Ulster County Area Social Security  332 Main St  Poughkeepsie NY 12601  Local Number 1-877-405-6747</p>	<p>Warren County Area Social Security  17 Cronin Road - Suite 1  Queensbury, NY 12804  Local Number 1-877-405-4875</p>
<p>Westchester County Area Social Security  Street Level - 85 Harrison Street  New Rochelle, NY 10550 1-800-772-1213</p>	

## Local Departments of Social Services

**Albany County DSS - 518-447-7300 – Main # 447-7492 - Medicaid**

162 Washington Avenue, Albany, New York 12210

**Allegany County DSS - 585-268-9622**

7 Court St, Belmont, New York 14813-1077

**Broome County DSS - 607-778-8850**

36-42 Main St, Binghamton, New York 13905-3199

**Cattaraugus County DSS - 716-373-8065**

Cattaraugus County Building, 1 Leo Moss Drive 6010, Olean, New York 14760-1158

**Cayuga County DSS -315-253-1011**

County Office Building, 160 Genesee St, Auburn, New York 13021-3433

**Chautauqua County DSS - 716-753-4421**

Hall R. Clothier Building, Mayville, New York 14757

**Chemung County DSS - 607-737-5302 Main # 737-5309 Commissioner's #**

Human Resource Center, 425 Pennsylvania Ave PO Box 588, Elmira, New York 14902

**Chenango County DSS - 607-337-1500**

PO Box 590, Court St, Norwich, New York 13815

**Clinton County DSS - 518-565-3300**

13 Durkee St, Plattsburgh, New York 12901-2911

**Columbia County DSS - 518-828-9411/12**

25 Railroad Avenue, PO Box 458, Hudson, New York 12534

**Cortland County DSS - 607-753-5248**

60 Central Avenue, Cortland, New York 13045-5590

**Delaware County DSS - 607-832-5300**

111 Main St, Delhi, New York 13753

**Dutchess County DSS - 845-486-3000**

60 Market St, Poughkeepsie, New York 12601-3299

**Erie County DSS - 716-858-8000**

95 Franklin St, Buffalo, New York 14202-3959

**Essex County DSS - 518-873-3441**

7551 Court St, PO Box 217, Elizabethtown, New York 12932-0217

**Franklin County DSS - 518-481-1808**

355 W. Main St, Malone, New York 12953

**Fulton County DSS - 518-736-5600 Main # 736-5640 Commissioner's**

4 Daisy Lane, PO Box 549, Johnstown, New York 12095

**Genesee County DSS - 585-344-2580**

5130 East Main St, Suite #3, Batavia, New York 14020

**Greene County DSS - 518-943-3200**

411 Main St, PO Box 528, Catskill, New York 12414-1716

**Hamilton County DSS - 518-648-6131**

PO Box 725, White Birch Lane, Indian Lake, New York 12842-0725

**Herkimer County DSS - 315-867-1291**

301 North Washington St, Suite 2110, Herkimer, New York 13350

**Jefferson County DSS - 315-782-9030**

250 Arsenal St, Watertown, New York 1360

**Lewis County DSS - 315-376-5400**

PO Box 193, Lowville, New York 13367

**Livingston County DSS - 585-243-7300**

1 Murray Hill Drive, Mt. Morris, New York 14510-1699

**Madison County DSS - 315-366-2211**

PO Box 637, North Court St, Wampsville, New York 13163

**Monroe County DSS - 585-753-2740**

111 Westfall Rd, Rochester, New York 14620-4686

**Montgomery County DSS - 518-853-4646**

County Office Building, PO Box 745, Fonda, New York 12068

**Nassau County DSS - Main # 227-8516**

60 Charles Lindbergh Blvd., Uniondale, New York 11553-3656

**New York City –NYC, 718-557-1399 [within the 5 NYC boroughs]**

Human Resources Administration

**Niagara County DSS - 716-439-7600**

20 East Avenue, PO Box 506, Lockport, New York 14095-0506

**Oneida County DSS - Main # 315-798-5700 Medicaid**

800 Park Avenue, Utica, New York 13501-2981

**Onondaga County DSS - 315-435-2985 Main #315-435-2928 Medicaid**

Onondaga County Civic Center, 421 Montgomery St, Syracuse, New York 13202-2923

**Ontario County DSS - 585-396-4060, (Outside the County area 1-877-814-6907)**

3010 County Complex Drive, Canandaigua, New York 14424-1296

**Orange County DSS - 845-291-4000**

Box Z, 11 Quarry Road, Goshen, New York 10924-0678

**Orleans County DSS - 585-589-7000**

14016 Route 31 West, Albion, New York 14411-9365

**Oswego County DSS - 315-963-5000**

100 Spring St, PO Box 1320, Mexico, New York 13114

**Otsego County DSS - 607-547-1700**

County Office Building, 197 Main St, Cooperstown, New York 13326-1196

**Putnam County DSS - 845-808-1500**

110 Old Route Six Center, Carmel, New York 10512-2110

**Rensselaer County DSS - 518-266-7970**

Franklin Square, 547 River St, Troy, New York 12180-8403

**Rockland County DSS - 845-364-3100 Main #845-364-3040 Medicaid**

Building L, Sanatorium Road, Pomona, New York 10970

**Saratoga County DSS - 518-884-4140 Commissioner's #518-884-4148 Medicaid**

152 West High St, Ballston Spa, New York 12020

**Schenectady County DSS - 518-388-4470**

797 Broadway, Schenectady, New York 12308-1812

**Schoharie County DSS - 518-295-8334**

County Office Building, PO Box 687, Schoharie, New York 12157

**Schuyler County DSS - 607-535-8303**

323 Owego St, Montour Falls, New York 14865

**Seneca County DSS - 315-539-1800**

1 DiPronio Drive, PO Box 690, Waterloo, New York 13165-0690

**St. Lawrence County DSS - 315-379-2111**

Harold B. Smith County Office Bldg., 6 Judson Street, Canton, New York 13617-1197

**St. Regis Mohawk Tribe 518-358-2272 DSS 518-358-2728**

412 State Rte. 37 Akwesasne NY 13655

**Steuben County DSS - 607-776-7611**

3 East Pulteney Square, Bath, New York 14810

**Suffolk County DSS - 631-854-9700 - Main #**

3085 Veterans Memorial Highway, Ronkonkoma, New York 11788-8900

**New App for Medicaid/Assist**

- R'head: 631-852-3710

- H'pauge: 631-853-8730

**Open Cases for Medicaid/Assist**

- R'head: 631-852-3570

- H'Pauge: 631-853-8765

**Sullivan County DSS – 845-292-0100**

P.O. Box 231, 16 Community Lane, Liberty, New York 12754

**Tioga County DSS - 607-687-8300**

PO Box 240, Owego, New York 13827

**Tompkins County DSS -607-274-5252, Commissioner's 607-274-5359 Medicaid**

320 West State St, Ithaca, New York 14850

**Ulster County DSS - 845-334-5000**

1061 Development Court, Kingston, New York 12401-1959

**Warren County DSS - 518-761-6300 Main #518-761-6321 Medicaid**

Municipal Center Annex , 1340 State Route 9 , Lake George, New York 12845-9803

**Washington County DSS - 518-746-2300**

Municipal Building, 383 Broadway, Fort Edward, New York 12828

**Wayne County DSS - 315-946-4881**

77 Water St, PO Box 10, Lyons, New York 14489-0010

**Westchester County DSS - 914-995-3333**

85 Court St, White Plains, New York 10601

**Wyoming County DSS - 585-786-8900**

466 North Main St, Warsaw, New York 14569-1080

**Yates County DSS - 315-536-5183**

County Office Building, 417 Liberty St. Suite 2122, Penn Yan, New York 14527-11184

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