Health Insurance Information, Counseling and Assistance Program (HIICAP) Guide for Counselors 2025

HIICAP Help Line:
1-800-701-0501

NEW YORK STATE
Office for the Aging
Health Insurance Information, Counseling and Assistance Program

Website: https://aging.ny.gov/hiicap-counselors-corner

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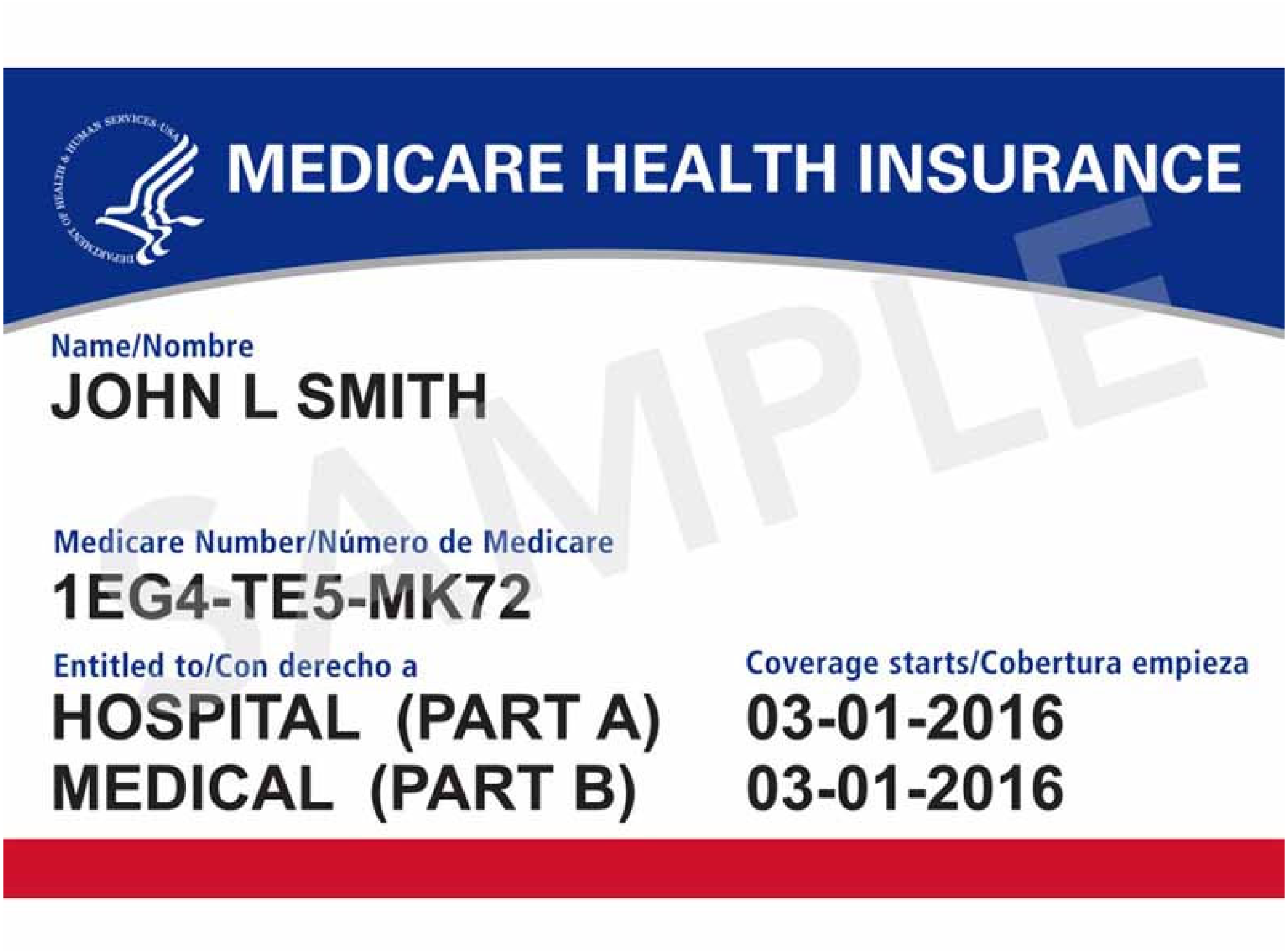
For HIICAP Counselors Only

Not for Public Distribution

Sample Medicare Health Insurance Card:



Social Security National Line: 1-800-772-1213
8:00 a.m. – 7:00 p.m., Monday – Friday
Social Security office locator:
https://secure.ssa.gov/ICON/main.jsp

HIICAP Introduction

In New York State, the SHIP program is referred to as the Health Insurance Information, Counseling and Assistance Program (HIICAP).

HIICAP is comprised of New York State Office for the Aging (NYSOFA) HIICAP staff, a network of 59 county-based HIICAPs, and six state-contracted Managed Care Consumer Assistance Programs (MCCAPs) – the Medicare Rights Center, New York State Senior Action Council, New York Legal Assistance Group, Legal Aid Society of New York, Empire Justice Center, and Community Service Society.

Through this network, over 700 trained HIICAP counselors work directly with Medicare beneficiaries to educate them about the Medicare program, Medigap policies, Medicaid, Medicare Advantage Plans, Long-term Care Insurance, Low-Income Subsidy Programs, employer-sponsored insurance, and other health insurance programs available in New York State. The HIICAP mission is to empower, educate, and assist Medicare-eligible individuals through objective outreach, counseling, and training. The HIICAP vision is to be the known and trusted community resource for Medicare information. HIICAP counseling is local, objective, confidential and knowledgeable, whether in-person or virtual.

The local HIICAP program coordinator manages the program, acting as a liaison to federal, state, and local agencies. The coordinator provides consumer education and outreach, and recruits, interviews, trains and supports HIICAP volunteer counselors.

Trained counselors, stationed either at their local area agency on aging or at another community agency, educate and assist Medicare beneficiaries. Based on feedback from local programs, NYSOFA HIICAP develops new educational materials, new methods of problem resolution, and shares local and state trends to comply with federal reporting requirements.

To obtain HIICAP services, Medicare beneficiaries can contact their local program or call the New York State HIICAP line at 1-800-701-0501. Callers will be routed to their local HIICAP program to speak with a trained counselor. HIICAP is federally funded program and receives funding from the New York State Office for the Aging.

All material distributed by local HIICAP should include appropriate state, local and national SHIP TA logos as well as the below statement:

The information provided by the Health Insurance Information, Counseling and Assistance Program is intended for the sole purpose of educating consumers in regard to the choices available for their health insurance needs. Particular emphasis is placed on understanding original Medicare. Nothing herein is intended, nor should it be construed, as an endorsement by the State of New York of any specific insurance product or insurer.

New Counselors, Volunteers and Coordinators (Team members)

NYSOFA HIICAP provides annual training and certification to all counselors, coordinators, and volunteers (team members).

The HIICAP coordinator in each county manages the program, acts as liaison to federal, state, and local agencies, provides consumer education and outreach, and recruits, interviews, trains and supports HIICAP volunteer counselors.

To be considered an active, properly screened, and trained coordinator, counselor, or volunteer, you must have completed the program-specific required screenings and trainings. This includes course work available in the SHIP TA Center, counselor shadowing, certification by NY HIICAP through the annual exam, and having a signed agreement or Memorandum of Understanding (MOU) with the local program. Once training and certification is complete HIICAP counselors can:

- Provide free, clear, accurate counseling and information.
- Educate consumers about Medicare benefits.
- Help consumers understand the Medicare prescription drug benefit.
- Help clients to determine whether they qualify for Low Income Subsidy Programs such as the Medicare Savings Program.

NYSOFA Resources and Training Opportunities

- HIICAP Notebook: the HIICAP Notebook organizes Medicare information into modules to help counselors better understand Medicare, Medigaps, Medicare Advantage, Low Income Subsidy Programs, and more. The Notebook is only available electronically and can be found on our NYSOFA HIICAP Corner at https://aging.ny.gov/hiicap-notebook.
- The annual HIICAP coordinators conference held in September is for coordinators only. This training offers important program updates and networking opportunities.
- Regional trainings are open to counselors and volunteers throughout the state. These take place in the fall prior to the Annual Open Enrollment Period.
- Two spring trainings offered by the Medicare Rights Center are open to all coordinators and counselors.
- New Coordinators training – held virtually as onboarding occurs throughout the year.
- HIICAP monthly coordinators calls – typically held the third Tuesday of each month;

information is sent out to coordinators prior to the monthly call.

- HIICAP email updates are used to share important Medicare and program information. All new coordinators are added to our NYSOFA HIICAP listserv.

- HIICAP Counselor's Corner is a dedicated site developed to provide counselors and coordinators with online resources at https://aging.ny.gov/hiicap-counselors-corner.

- HIICAP counselors meet with their peers and their coordinator for ongoing education and updates.

- HIICAP counselors complete an annual exam. The Annual HIICAP Counselor Exam can be found online in the training and certification section of SHIP TA at https://portal.shiptacenter.org/Login.aspx.

- HIICAP also has a webpage (https://aging.ny.gov/programs/medicare-and-health-insurance) providing information to Medicare beneficiaries and counselors.

- CMS Publications such as the annual *Medicare and You* guide can be ordered through CMS's product ordering site. To create an account, go to http://productordering.cms.hhs.gov/. CMS will not ship items to a P.O. Box.

Additional Resources

In addition to the above resources, New York HIICAP also offers the Medicare Rights Center technical assistance and education resources, Medicare Interactive (at http://www.medicareinteractive.org), *Medicare Counselor* and the *Dear Marci* newsletter, and a dedicated HIICAP email for case assistance at HIICAP@medicarerights.org.

The Managed Care Consumer Assistance Programs are also available to assist counselors and low-income beneficiaries with Part D appeals, exceptions, prior authorization requests and other health insurance issues, and may provide free legal representation. Our state MCCAP partners are below.

MCCAP – NAME	Phone number	Website/email
Community Service Society	212-254-8900	https://www.cssny.org/
Empire Justice Center	518-462-6831	https://empirejustice.org/
The Legal Aid Society	1-212-577-3300 (NYC area) 1-833-628-0087 (upstate)	https://legalaidnyc.org/
Medicare Rights Center	1-800-333-4114 (consumer) 1-800-480-2060 (HIICAPs)	https://www.medicarerights.org/
New York Legal Assistance Group	212-613-5000	https://nylag.org/
Statewide Senior Action Council	1-800-333-4374	https://www.nysenior.org/

SHIP Unique ID

A SHIP Unique ID allows trained HIICAP counselors to speak with a plan or CMS without the beneficiary being present. Because SHIP Unique IDs are intended for resolving complex beneficiary cases, they will not be needed by every team member. A SHIP Unique ID may be approved by NYSOFA HIICAP for active, properly screened, and trained team members who have completed the annual confidentiality agreement and have received annual privacy training.

Requesting an ID

To request a SHIP Unique ID, a counselor must be registered in the Federal SHIP Tracking and Reporting System (STARS), complete Medicare basic course work in SHIP TA, complete the annual HIICAP exam, and shadow a more experienced counselor for additional training. The counselor will need to have reported counseling activity into STARS prior to approval.

NYSOFA HIICAP will review all requests for a SHIP Unique ID (this can take up to 7 days). If the request is appropriate, it will be approved. The SHIP Unique ID will then be activated the following month. Reporting is mandatory to maintain a SHIP Unique ID. 120 days of inactive counseling activity will result in a revoked SHIP Unique ID.

Annual Recertification

All SHIP Unique ID confidentiality agreements and privacy training will need to be completed annually. After completing privacy training, all those with a SHIP Unique ID will be required to sign and date the updated confidentiality agreement and fax it to NYSOFA HIICAP for approval. Annual SHIP Unique ID information is sent to local HIICAP program coordinators through a NYSOFA issued program instruction (PI). HIICAP coordinators are responsible for managing the annual SHIP Unique ID training and confidentiality agreements.

As a reminder, when onboarding new HIICAP/MIPPA counselors, the following steps need to be followed:

- New HIICAP team members (coordinators, counselors, and volunteers) must complete all required screening and training; this includes counselor shadowing, a signed agreement or Memorandum of Understanding (MOU) with the local program, completion of course work, and the annual HIICAP exam available in the SHIP TA Center. New counselors can self-register as SHIP Counselors in the SHIP TA Center website at https://portal.shiptacenter.org/Registration/Default.aspx.

- All coordinators, counselors, and volunteers will need to be registered in the federal SHIP Tracking and Reporting System (STARS). To register new counselors and volunteers in the STARS system, you will need to send a completed team member profile form to our office via fax at (518) 486-2225 only.

- Please **do not** create new Team Members in STARS. The NYS State HIICAP Team is responsible for team member creation in STARS. Please send requests for new team members to Helen Fang. Once we receive the completed form, we will then create the new team member profile in STARS. New users will then receive a "Welcome to STARS" email with log-in information. This automatic email message may land in the counselor's spam folder, so please check these folders.

- If requesting a SHIP Unique ID for a new counselor conducting complex casework, the counselor must be registered in the Federal SHIP Tracking and Reporting System (STARS) and have completed all training outlined above. The signed (annual) confidentiality agreement form must be sent to NY HIICAP via fax only. NY HIICAP will review all requests (this can take up to 7 days). If the request is appropriate, it will be approved. The CMS SHIP Unique ID will then be activated the following month. Counselors with the CMS SHIP Unique ID are required to review and attest to the NYS Privacy Training as part of the annual recertification process.

Reminder: Reporting of beneficiary contacts is mandatory to maintain a SHIP Unique ID. After 120 days of inactive counseling, the SHIP Unique ID will automatically be revoked.

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Medicare - Part A
Hospital Coverage

Hospital 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.

Deductible per benefit period: $1,676 (Paid upon admission in a hospital)

Day	1-60	$0 coinsurance for each benefit period
Days	61-90	$419 coinsurance per day for each benefit period
Days	91 & beyond	$838 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over a beneficiary's lifetime)
Days	Beyond	All costs beyond lifetime reserve days

Skilled Nursing Facility

Day	1-20	$0 for each benefit period
Days	21-100	$209.50 coinsurance per day of each benefit period
Days	101 & beyond	All costs for each day

If a beneficiary stops getting skilled care in the SNF, or leaves the SNF altogether, their SNF coverage may be affected depending on how long their break in SNF care lasts.

If a beneficiary's break in skilled care lasts more than 30 days, they will 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 the beneficiary was treated for during their previous stay.

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

Eligibility: Age 65 and Older

- A beneficiary or their spouse (or former spouse) had at least 10 years (or 40 calendar quarters) of employment in which they paid Social Security taxes.

- Would be entitled to Social Security benefits based on the beneficiary's spouse's (or divorced spouse's) work record, and that spouse is at least 62 (a beneficiary's spouse does not have to apply for benefits to be eligible based on the beneficiary's spouse's work).

- Receive Social Security or railroad retirement benefits.

- Are not getting Social Security or railroad retirement benefits, but the beneficiary worked long enough to be eligible for benefit.

- Worked long enough in a federal, state, or local government job to be insured for Medicare.

Eligibility 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

- Diagnosed with End-Stage Renal Disease (ESRD) and receiving dialysis treatments or had a kidney transplant; or

- Worked long enough in a federal, state, or local government job and the beneficiary meets the requirement of the Social Security disability program.

Enrollment

- For those already receiving Social Security benefits (including Railroad 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 online at http://www.ssa.gov.

Premium (2025)

40 or more working quarters	$0
30-39 working quarters	$285.00/month
Less than 30 working quarters	$518.00/month

Medicare - Part B
Outpatient Services

Part B helps cover services from doctors and other health care providers, outpatient care, home health care, durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment), and many preventive services (like screenings, shots, or vaccines, and yearly “wellness” visits).

The standard Part B premium amount in 2025 is $185.00 (or higher depending on the beneficiary’s income). However, some people who get Social Security benefits pay less than this amount. A beneficiary will pay the standard premium amount (or higher) if:

- The beneficiary enrolls in Part B for the first time in 2025.
- The beneficiary does not receive Social Security benefits.
- The beneficiary is directly billed for their Part B premiums (meaning they aren't taken out of the beneficiary’s Social Security benefits).
- The beneficiary has Medicare and Medicaid, and Medicaid pays the premiums (the beneficiary’s state will pay the standard premium amount).
- The beneficiary’s modified adjusted gross income, as reported on their IRS tax return from two years ago, is above a certain amount. If so, the beneficiary will pay the standard premium amount and an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to a beneficiary’s premium.

If the beneficiary is in 1 of the 5 groups mentioned above, the following chart outlines what they will pay in 2025.

2023 Beneficiary Income (individual tax return)	**2023 Beneficiary Income** (joint tax return)	**2023 Beneficiary Income** (Married, separate tax return)	**Monthly Premium 2025**
$106,000 or less	$212,000 or less	$106,000 or less	$185.00
$106,001+ up to $133,000	$212,001+ up to $266,000	Not applicable	$259.00
$133,001+ up to $167,000	$266,001+ up to $334,000	Not applicable	$370.00
$167,001+ up to $200,000	$334,001+ up to $400,000	Not applicable	$480.90

$200,001+ but less than $500,000	$400,001+ but less than $750,000	$106,001+ but less than $394,000	$591.90
$500,000 or above	$750,000 or above	$394,000 and above	$628.90

Cost for services

- **Coinsurance**: Usually, 20% of the cost for each Medicare-covered service or item after the deductible has been paid (and the doctor or health care provider accepts the Medicare-approved amount as full payment – called “accepting assignment”).
- Annual **deductible**: $257.00 before Original Medicare starts to pay. A beneficiary pays this deductible once each year.
- 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.

Eligibility for Part B

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.
- Be either a U.S. citizen **OR** 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.

If a beneficiary is under the age of 65, they must meet the same criteria noted above (for persons aged 65 and up) and are receiving Social Security Disability Insurance (SSDI) for more than 24 months, or are 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.

A beneficiary can enroll in Part B through Social Security at 1-800-772-1213 or online at http://www.ssa.gov.

Part B Enrollment Periods

- General Enrollment Period: January 1 to March 31 of each year. Coverage will begin the first of the following month of enrollment.

- Initial Enrollment Period: A person has 7 months surrounding their 65th birthday to join Part B (3 months prior to the month of birthday, and 3 months after).

When to enroll in Part A and/or Part B	**Coverage starts**
3 months before a beneficiary turns 65	The first day of the month of the beneficiary's 65th birthday
The month a beneficiary turns 65	1 month after the beneficiary signs up
1 month after a beneficiary turns 65	The first of the following month of enrollment
2 months after a beneficiary turns 65	The first of the following month of enrollment
3 months after a beneficiary turns 65	The first of the following month of enrollment
During the General Enrollment Period (January 1 – March 31)	The first of the following month of enrollment

Special Enrollment Period (SEP)

Individuals may enroll during the SEP if they 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). 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.

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. A beneficiary can remove the Late Enrollment Penalty if they are eligible for a Medicare Savings Program (MSP). If a beneficiary is under age 65 and receiving Medicare Part B with penalty, the Late Enrollment Penalty is waived (removed) at the time of their 65th birthday. Equitable Relief can be used for enrollment or to appeal a Late Enrollment Penalty.

Equitable Relief

Equitable relief is an administrative process that allows a beneficiary to request the following from the Social Security Administration (SSA):

- Immediate or retroactive Medicare enrollment
- Elimination of the Medicare Part B late enrollment penalty (LEP)

To request equitable relief, the beneficiary must have failed to enroll in Medicare due to the error, misrepresentation, or inaction of a federal employee, such as a Social Security or 1-800-MEDICARE representative. Equitable relief does not apply if the beneficiary was misinformed about their Medicare rights and options by others, such as an employer.

Example: A beneficiary did not enroll in Part B because a Social Security representative said that they did not need to sign up. Because the beneficiary failed to enroll due to an error caused by misinformation from a federal employee, the beneficiary may have grounds for receiving equitable relief.

Requesting Equitable Relief

To request equitable relief, the beneficiary or their representative should write a letter to their local Social Security office explaining that they received misinformation that caused them to delay enrollment. Local offices can be found by calling 800-772-1213 or visiting www.ssa.gov/locator.

The person writing the letter (beneficiary or representative) should be as specific as possible and include the name of the representative who provided the wrong information, date and time of the conversation, outcome of the conversation, and any additional notes.

The letter should indicate whether the beneficiary is requesting coverage going forward, retroactive coverage, and/or elimination of Part B LEP. Keep in mind that if retroactive coverage is requested, the beneficiary will have to pay premiums back to the date the coverage begins.

The beneficiary or representative should follow up with the request approximately one month after the request is submitted. The beneficiary may also want to contact a legislative representative, such as a member of Congress, and ask them to follow up on the case.

Social Security is not required to respond to equitable relief requests within any set timeframe. They are also not obligated to send the beneficiary a formal decision letter in response to the request.

If a beneficiary is denied equitable relief, there is no formal appeal process, but the beneficiary can resubmit the request with more or different information as many times as they wish.

Sample Equitable relief letter (for illustrative purposes). Find a downloadable version at: https://www.medicarerights.org/fliers/Part-B-Enrollment/Equitable-Relief.pdf?nrd=1

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 **[Social Security/other federal agency]** 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 including names and dates. Best practice is to create a timeline of relevant contact with federal agents.]

HI 00805.170 Conditions for Providing Equitable Relief
https://secure.ssa.gov/poms.nsf/lnx/0600805170

> SSA/CMS may take action to prevent or correct inequity to the individual when his/her SMI or Premium-HI enrollment, termination, or coverage rights are prejudiced because of the error, misrepresentation, or inaction of an employee or agent of the Government.
>
> The actions include (but are not limited to) the designation of enrollment and coverage periods, and appropriate adjustment of premium liability.

Pursuant to the above citation, 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]**

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. Many Advantage plans include Part D prescription coverage. In addition to the Medicare monthly Part B premium responsibility, some plans may charge an extra monthly premium. A beneficiary 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.

Types of Medicare Advantage Plans

Health Maintenance Organization (HMO) – In HMO Plans, a beneficiary generally must get their care and services from doctors, other health care providers, or hospitals in the plan's network, with the following exceptions: emergency care, out-of-area urgent care, and out-of-area dialysis. In some plans, a beneficiary may be able to go out-of-network for certain services, but it usually costs less if care is received 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, the beneficiary pays less if they use doctors, hospitals, and other health care providers who belong to the plan's network. The beneficiary will pay more if they 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 the beneficiary must pay when they get care. Under a PFFS plan, a beneficiary 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. Some PFFS plans offer Part D coverage, and some plans do not. If the PFFS plan does not offer Part D coverage, the beneficiary can enroll in a stand-alone Part D plan.

Special 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, 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. Some SNPs for people with Medicare and Medicaid are also available to beneficiaries with QMB who do not also have Medicaid.

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 - Part D
Prescription Coverage

The Medicare Part D prescription drug benefit is the part of Medicare that covers most outpatient prescription drugs. Part D is offered through private companies either as a stand-alone plan, for those enrolled in Original Medicare, or as a set of benefits included with a Medicare Advantage Plan. A beneficiary must be enrolled in Medicare Part A and/or B to enroll in Medicare Part D.

Medicare offers prescription drug coverage to everyone with Medicare. If a beneficiary decides not to get Medicare drug coverage when first eligible, they will likely pay a late enrollment penalty unless they have other creditable prescription drug coverage or they receive Extra Help. To get Medicare drug coverage, a beneficiary 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 a beneficiary can obtain Medicare drug coverage: through a Medicare Prescription Drug Plan (Part D) or a Medicare Advantage Plan (Part C) (like an HMO or PPO).

Deductible

Until a beneficiary meets their Part D deductible (up to $590 in 2025), they will pay the full negotiated price for their covered prescription drugs. Once a beneficiary meets the deductible, the plan will begin to cover the cost of the drugs.

Initial Coverage Period

After a beneficiary meets their deductible, the plan will help pay for their covered prescription drugs. The plan will pay some of the cost, and the beneficiary will pay a copayment or coinsurance. In 2025, the initial coverage stage ends once their out-of-pocket spending on covered Part D drugs reaches $2,000 (including certain payments made on their behalf, i.e. Extra Help). At this point, the beneficiary will automatically receive catastrophic coverage

Catastrophic Coverage Period

A beneficiary enters catastrophic coverage after they reach $2,000 in out-of-pocket costs for covered drugs. In 2025, once a beneficiary has reached the catastrophic coverage stage, they won't have to pay any out-of-pocket costs for covered Part D drugs for the rest of the calendar year. Please see the Medicare Part D Cost Sharing Chart on the following page.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with a beneficiary's current drug coverage to help them manage their out-of-pocket costs for drugs that are covered by their plan. The payment plan assists beneficiaries by spreading costs across the calendar year (January-December). A beneficiary that has a stand-alone Part D plan or a Medicare Advantage Plan with drug coverage may utilize this payment option. The payment plan is offered by all plans. Participation is voluntary and there is no additional cost.

Medicare Part D Cost Sharing Chart 2025

Part D Benefit Cost Periods	Costs and Who Pays	Beneficiary Pays (TrOOP)	Plan Pays	Total Amount Spent on Plan-Covered Drugs
Initial Deductible	Beneficiary pays 100%	Up to $590	$0	**$590** (Amount spent on deductible, before ICP begins)
Initial Coverage Period (ICP)	Costs of covered drugs are shared: 25% by beneficiary, 75% by plan	Up to $1,410 (max a person would pay for covered drugs with no deductible)	$1,057.50	**$2,000** (Amount spent during ICP, including applicable deductible, before Catastrophic Coverage begins)
Catastrophic Benefit Period	When an enrollee's total out-of-pocket spending reaches $2,000, they hit the catastrophic benefits period. After this point, the beneficiary does not have to pay anything for their prescription drugs for the rest of the year.	$0	100%	Beneficiary will remain in the Catastrophic Benefit Period through December 31, 2025. Part D benefit will reset on January 1, 2026, starting again with a deductible.

Source: Centers for Medicare & Medicaid Services (CMS)
https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-cms-implements-improvements

Late Enrollment Penalty

Generally, a beneficiary 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 that the beneficiary delays enrollment. The average national premium in 2025 is $36.78 a month. For example, if a beneficiary delayed enrollment for five months, their monthly penalty would be $1.90 ($36.78 X 1% = $0.37; $0.37 X 5 months = $1.85; $1.85 (rounded up to nearest $0.10) = $1.90). This penalty will be added to the person's plan premium.

LEP Reconsideration (Appeal) Process

An enrollee may use the "Part D LEP Reconsideration Request Form C2C" to request an appeal of a Late Enrollment Penalty decision. The enrollee must complete the form, sign it, and send it to the Independent Review Entity (IRE) as instructed in the form. The Part D Appeal Reconsideration Form can be found at: https://www.cms.gov/files/document/part-d-lep-reconsideration-request-form-c2c.pdf.

The LEP reconsideration is conducted by an IRE under contract with Medicare. The IRE generally will notify the enrollee of the final LEP reconsideration decision (including a decision to dismiss the reconsideration request) within 90 calendar days of receiving a request for reconsideration.

Limited Income Newly Eligible Transition Program (LINET)

LINET provides immediate prescription coverage for Medicare beneficiaries who qualify for Medicaid or Extra Help and have no prescription drug coverage. Enrollment in LINET is temporary, usually for 1 to 2 months. This temporary coverage provides time for the beneficiary to choose a Medicare Part D prescription drug plan. If a Part D plan is not selected, Medicare will automatically enroll the individual into a benchmark plan.

If the individual is eligible for LINET, ask the pharmacist to submit a claim to LINET using the following:

- BIN = 015599
- PCN = 005440000
- Group ID = may be left blank
- Cardholder ID = Beneficiary Medicare Health Insurance Claim Number (HICN) including letter
- Patient ID = Medicaid ID or Social Security Number
- The Limited Income NET Program Payer sheet, which can be found at https://www.humana.com/LINET

For claims that are paid out-of-pocket, beneficiaries should submit receipts to:

Medicare Limited Income NET Program
PO Box 14310
Lexington, KY 40512-4310

If a beneficiary has additional questions, they can contact the LINET help desk at 800-783-1307. For problems at the pharmacy with Medicaid billing, contact eMedNY at 1-800-343-9000.

Transition Policy

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:

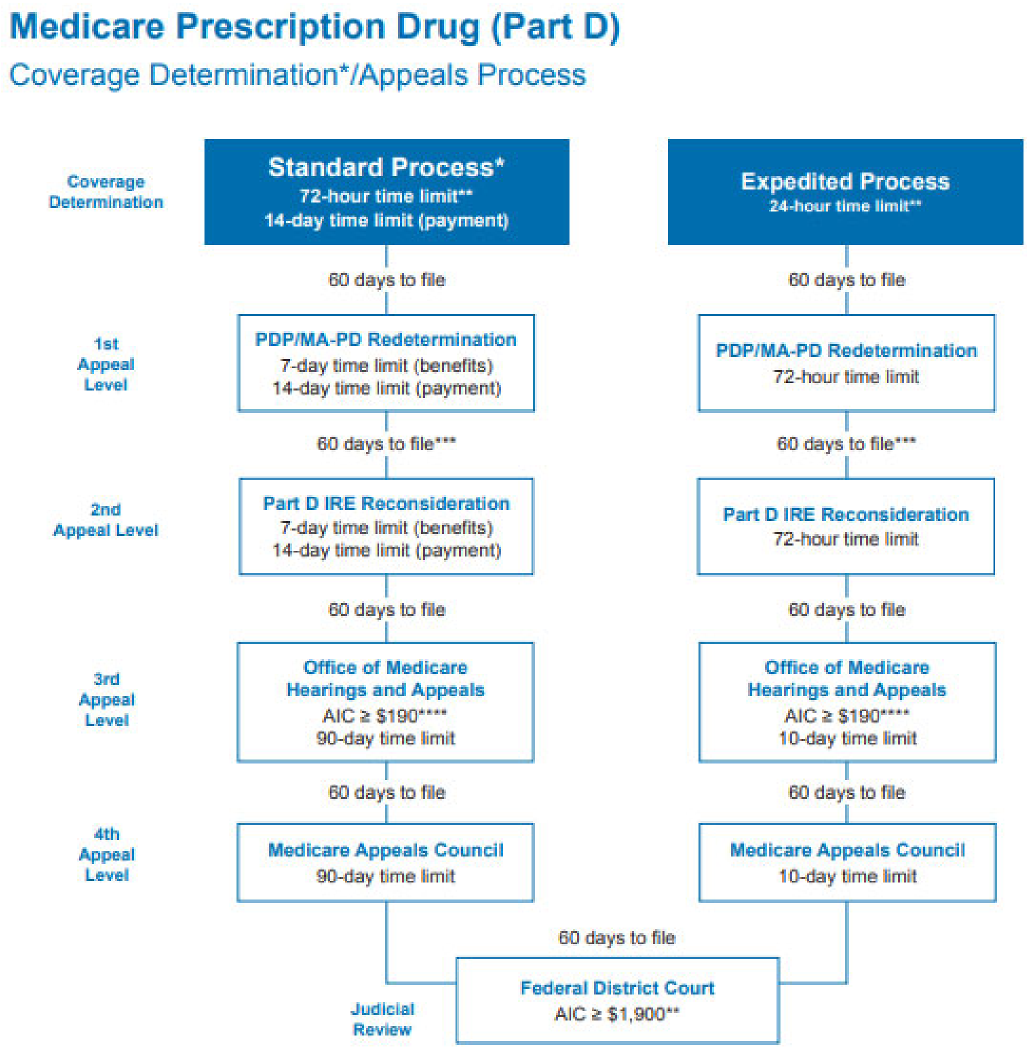
- Temporary
- Not for new prescriptions
- Filled up to 90 days after joining a plan

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"), the beneficiary can file an 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 the beneficiary is 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.

Part D Appeal Process Chart (for illustrative purposes).
Find a downloadable version at: https://www.cms.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev/downloads/flowchart-medicare-part-d.pdf



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.

*** If, on redetermination, a plan sponsor upholds an at-risk determination made per 42 CFR § 423.153(f), the plan sponsor must auto-forward the case to the Part D IRE.

****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 2025.

Medicare
Enrollment Periods

Annual Election Period (AEP)

- October 15 to December 7
- A person can drop, pick-up or switch any health plan options.
- Changes are effective January 1 of the following year.

General Enrollment Period (GEP)

- January 1 to March 31
- For individuals who missed their Medicare Part B IEP.
- Coverage effective date will be the first of the following month of enrollment.

5 Star Special Enrollment Period

- December 8 until November 30 of the following year (i.e. 12/8/24 - 11/30/25)
- A one-time SEP during the above dates
- People can switch to a 5-Star Medicare Advantage plan (with or without drugs), or 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 Presctiption Drug Plan or 5 Star Medicare Advantage for the first time.
- Enrollment is effective the first day of the following month.

Initial Enrollment Period (IEP)

- For individuals upon first meeting the eligibility requirements for Medicare.
- An eligible person 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 to March 31
- Beneficiaries on a Medicare Advantage Plan (with or without Part D) can switch to either another Medicare Advantage Plan or to Original Medicare.
- Effective the 1st of the following month.

Special Enrollment Periods

Due to CMS amending rules for some special enrollment periods, please refer to the Special Enrollment Chart developed by the Medicare Rights Center to view the special enrollment periods available. The chart is at https://www.medicareinteractive.org/pdf/SEP-Chart.pdf.

Medicare
Rules and Resources

Accountable Care Organizations (ACOs)

ACOs are 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.

Ambulance Coverage

Beneficiaries can get emergency ambulance transportation when they experience a sudden medical emergency, and their health is in danger because they can’t be safely transported by others by car or taxi. The ambulance provider must accept Medicare assignment and bill Medicare directly, meaning they must accept the Medicare-approved amount. Medicare will pay for 80% of the approved amount, and the beneficiary will be responsible for 20% co-insurance. Some Medicare Advantage Plans may offer additional transportation services.

Non-emergency ambulance coverage is limited. Beneficiaries may be able to get non-emergency ambulance transportation when they have a written order from their doctor saying that ambulance transportation is medically necessary. Medicare will never pay for ambulette services.

Limiting Charge-Balance Billing

In New York State, limits apply to the amount a physician may charge a Medicare beneficiary. The limit is 105% of the amount approved by Medicare. For these services, the federal limit of 115% of the Medicare approved amount applies. The beneficiary is still required to pay the Medicare deductible and co-insurance. The law applies to more specialized services and treatments provided in a doctor’s office or clinic, to all physician treatments, and services provided on an inpatient basis in the hospital. It does not apply to participating doctors who accept Medicare assignment in all cases. In New York State, QMB-eligible enrollees are not responsible for any Medicare Part B Cost-Sharing.

Benefits Coordination and Recovery Center

The Benefits Coordination and Recovery Center (1-855-798-2627) 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.

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 the beneficiary’s bills first and then sends the rest to the "secondary payer" to pay. In some cases, there may also be a third payer.

Durable Medical Equipment (DME)

Round 2021 of the DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) Competitive Bidding Program (CBP) began on January 1, 2021, and expired on December 31, 2023.

Since January 1, 2024, there has been a temporary gap period for DMEPOS CBP.

During the temporary gap period, Medicare-enrolled DMEPOS suppliers may furnish DMEPOS items and services to patients. Here are the payment rules:

- Adjusted fees in former competitive bidding areas (CBAs) are based on 100% of the single payment amount for the CBA increased by the projected percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) from January 2023 to January 2024.

- Adjusted fees in non-CBAs are based on fully adjusted rates per the applicable methodology under https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.210.

Please see the CMS announcement for additional information. CMS is required by law to recompete contracts under the DMEPOS Competitive Bidding Program at least once every three years. More information is at https://www.medicare.gov/sites/default/files/2022-02/11461-DMEPOS-Competitive-Bidding-Program-Guide.pdf. To find a Medicare approved supplier in a specific area, check with the plan and/or go to https://www.medicare.gov/medical-equipment-suppliers/.

Foreign Travel

Medicare does not cover medical care outside of the country. If a beneficiary will be traveling to a foreign country and would like insurance, they should talk to their travel agent about special travel insurance. The only exceptions in which Medicare may cover medical care outside of the U.S. are outlined below.

- Medicare will pay for emergency services in Canada if a beneficiary is traveling a direct route between Alaska and another state.

- Medicare will pay for medical care provided to a beneficiary on a cruise ship if the beneficiary gets 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 inpatient services in a foreign hospital (and connected physician and ambulance costs). It is covered if it is closer to a beneficiary’s residence than the nearest U.S. hospital that is available and equipped to treat their medical condition. This may happen if, for example, a beneficiary lives near the border of Mexico or Canada.

- Medigap coverage exists outside the U.S in some circumstances. If a beneficiary has Medigap Plan C, D, F, G, M or N, the plan covers foreign travel emergency care if it begins during the first 60 days of the beneficiary's trip, and if Medicare doesn't otherwise cover the care. The plan pays 80% of the billed charges for certain medically necessary emergency care outside the U.S. after the beneficiary meets a $250 deductible for the year. Foreign travel emergency coverage with Medigap policies has a lifetime limit of $50,000.

If a person wishes to reside outside of the U.S., Medicare will not cover any health services. 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 General Enrollment Period (GEP) to enroll and will help avoid any penalties.

Home Health Care

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

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

A beneficiary is typically referred for home care 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. The agency will draft a "plan of care." The plan of care will need to be approved and certified by a doctor. Medicare-approved home health agencies can be found at http://www.medicare.gov/homehealthcompare/ and 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 Services

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 does not cover home health aide services unless an individual is also receiving skilled care. Skilled care includes skilled nursing care (other than drawing blood), physical therapy, speech-language pathology services, and continuing occupational therapy. If a person does not qualify to have a Medicare-approved aide, other programs may 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. A beneficiary can get Medicare hospice benefits when they meet all the following conditions:

- The beneficiary is eligible for Medicare Part A (hospital insurance).
- The beneficiary's doctor and the hospice medical director certify that the beneficiary is terminally ill (with a life expectancy of 6 months or less).
- The beneficiary signs a statement choosing hospice care instead of other Medicare-covered benefits to treat their terminal illness.
- The beneficiary gets care from a Medicare-approved hospice program.

The doctor and the hospice medical team will work with the beneficiary and family to establish 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. To find a hospice program in New York, call 1-800-Medicare or visit www.medicare.gov. You can also refer to CMS's publication on hospice at https://www.medicare.gov/pubs/pdf/02154-Medicare-Hospice-Benefits.pdf.

Mental Health

Medicare Part A covers inpatient mental health services that a beneficiary receives in either a psychiatric hospital (a hospital that only treats mental health patients) or a general hospital. Be aware that a beneficiary will have the same out-of-pocket costs regardless of whether they receive care in a general or psychiatric hospital. After meeting the Part A deductible, Original Medicare pays in full for the first 60 days of the benefit period. After day 60, the beneficiary will pay a daily hospital coinsurance.

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

- Individual and group therapy
- Substance abuse treatment
- Tests to make sure that the beneficiary is 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 the beneficiary's condition)
- Family counseling (if the purpose is to help with a beneficiary's treatment)
- Laboratory/diagnostic tests

- Prescription drugs that a beneficiary cannot administer themself, such as injections that a doctor must give them
- Medication management
- Partial hospitalization
- 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 a beneficiary stay in their home, such as shopping, meal preparation, and cleaning (unless the beneficiary is 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.
- 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, beneficiaries 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.

Medicare Therapy Limits

Medicare Part B (Medical Insurance) helps pay for medically necessary outpatient physical or occupational therapy, as well as speech-language pathology services. The therapy limits – $2,410 combined for physical therapy (PT) and speech-language pathology (SLP) and $2,410 for occupational therapy (OT) – apply to outpatient therapy received at therapists' or physicians' offices, an outpatient hospital, and home, when not part of a Medicare-covered home health benefit.

Once a beneficiary reaches therapy limits, their therapist will need to add a special code to the beneficiary's therapy claim. By adding this code, the therapist confirms that the beneficiary's therapy services are reasonable and necessary. The beneficiary will be responsible to pay 20% of the Medicare-approved amount, and the Part B deductible applies.

To keep up to date on these limitation amounts, visit the U.S. Centers for Medicare and Medicaid Services website at https://www.cms.gov/Medicare/Billing/TherapyServices.

Medigap
Medicare Supplemental Plans

Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. Medigap is a Medicare Supplement Insurance plan that helps pay some of the remaining health care costs, such as copayments, coinsurance, and deductibles. Medigap plans are sold by private insurance companies. To be eligible for a Medigap, a beneficiary must be enrolled in both Part A and Part B. Remember, Medigap insurance will only pay after Original Medicare pays first. If a beneficiary has a Medicare Advantage Plan, they cannot buy a Medigap.

New York State law and regulations 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.

Medigap Waiting Periods in New York State

Medigap policies may contain up to a six-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 New York State regulation, the waiting period may either be reduced or waived entirely, depending upon a beneficiary's individual circumstances.

Medigap insurers are required to reduce the waiting period by the number of days that the beneficiary was covered under some form of "creditable" coverage as long as there were no breaks in coverage of more than 63 calendar days. The following types of coverage are considered "creditable":

- 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.*

The pre-existing condition waiting period may be reduced by one month for each month a beneficiary was enrolled in creditable coverage prior to purchasing a Medigap. If they had creditable coverage for two months before purchasing a Medigap, their policy may only impose a four-month waiting period, instead of six months. If a beneficiary had six or more months of prior creditable coverage, Medigap insurers must cover their prior medical conditions immediately. Keep in mind that you cannot use creditable coverage to reduce your pre-existing waiting period if you had a break in coverage of more than 63 days.

For a list of Medigap plans in New York State, please visit:
https://www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates

For questions about Medigap policies, beneficiaries can contact the New York State Department of Financial Services at:

1-800-342-3736 (M-F 8:30 a.m. to 4:30 p.m.)
518-474-6600 (Albany)
212-480-6400 (New York City)
consumers@dfs.ny.gov

Dis-enrolling from a Medigap plan

A Medigap policy cannot be used to pay a beneficiary's Medicare Advantage Plan copayments, deductibles, and premiums. If a beneficiary has a Medigap policy and joins a Medicare Advantage Plan (Part C), they should drop their Medigap policy. To do so, a beneficiary needs to contact their insurance company.

If a beneficiary has a Medicare Advantage Plan, it is illegal for anyone to sell them a Medigap policy unless the beneficiary is switching back to Original Medicare. If the beneficiary disenrolls from the Medicare Advantage Plan, they might not be able to get the same Medigap policy back. If the beneficiary chooses to switch to Original Medicare and purchase a Medigap policy, the beneficiary should contact their Medicare Advantage Plan to see if they are able to disenroll.

Medigap plan benefit chart (for illustrative purposes). Find a downloadable version at: https://www.medicarerights.org/fliers/Medigaps/Whole-Medigap-Packet-(NY).pdf?nrd=1

MEDICARE RIGHTS CENTER
Getting Medicare right

2025 Medigap plan benefits

For plans sold on or after June 1, 2010

	A	B	C	D	F*	G*	K**	L**	M	N
Hospital coinsurance Coinsurance for days 61-90 ($419) and days 91-150 ($838) in hospital; Payment in full for 365 additional lifetime days	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪
Part B coinsurance 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
First three pints of blood	▪	▪	▪	▪	▪	▪	50%	75%	▪	▪
Hospital deductible Covers $1,676 in each benefit period		▪	▪	▪	▪	▪	50%	75%	50%	▪
Skilled nursing facility (SNF) daily coinsurance Covers $209.50 a day for days 21-100 each benefit period			▪	▪	▪	▪	50%	75%	▪	▪
Part B annual deductible Covers $257 (Part B deductible)			▪		▪					
Part B excess charges benefits 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)					▪	▪				
Emergency care outside the U.S. 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	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪
Hospice care Coinsurance for respite care and other Part A-covered services	▪	▪	▪	▪	▪	▪	50%	75%	▪	▪

Note: Plans C and F are only available to you if you became eligible for Medicare before January 1, 2020.

* Plans F & G also offer a high-deductible option. You pay a $2,870 deductible in 2025 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 2025 out-of-pocket maximum is $7,220 for Plan K and $3,610 for Plan L.

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 doesn't apply to Massachusetts, Minnesota and Wisconsin. Those states have their own Medigap systems.

 Helpline: 800-333-4114 www.medicareinteractive.org

Elderly Pharmaceutical Insurance Coverage (EPIC) Program

The Elderly Pharmaceutical Insurance Coverage (EPIC) program is a New York State Pharmaceutical Prescription Assistance Program (SPAP) sponsored by the Department of Health for income-eligible seniors 65 years old or older to supplement their out-of-pocket Medicare Part D drug plan cost.

Eligibility:

- Be a New York State resident aged 65 years old or older.
- Have an annual income (based on prior year's income) below $75,000 if single or $100,000 if married.
- Be enrolled or eligible to be enrolled in a Medicare Part D plan.
- Not be receiving full Medicaid benefits.

EPIC Coverage:

EPIC will provide secondary coverage for Medicare Part D and EPIC covered drugs purchased during the:

- Initial Coverage Period

EPIC will also cover many Medicare Part D excluded drugs such as prescription vitamins and prescription cough and cold preparations.

- All prescriptions must be covered as primary under Medicare Part D plan formulary.
- Drug manufacturer must be participating in the New York State Rebate program.

EPIC Benefits

EPIC provides prescription co-pay assistance, lowering Part D co-pays.

- 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. Once the member is using their EPIC benefit, they should not pay more than $20 for their prescriptions.

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 and Medicare Part D Premium Assistance

EPIC provides income-based Part D premium assistance at $72.34 per month for 2025. Income levels are:

- $23,000 or less (single)
- $29,000 or less (married)

Special Enrollment Period (SEP)

EPIC members will receive a yearly SEP to join or switch a Medicare Part D plan.

- EPIC members receive a Special Enrollment Period (SEP) in addition to the Medicare Annual Enrollment Period (AEP)
- The SEP cannot be used to drop a Part D plan

Note: New members are eligible for the SEP once they receive their EPIC Identification Number.

EPIC Plans:

EPIC has two plans based on income.

Fee Plan:

- Single with income of up to $20,000
- Married with joint income of up to $26,000.
- Fee Plan members pay an annual fee ranging from $8 to $300. Members are billed in quarterly installments or can be paid annually. All fee plan members will receive Medicare Part D assistance up to $72.34 per month in 2025.

Deductible Plan:

- Single with income from $20,001 and $75,000.
- Married with joint income from $26,001 and $100,000.
- EPIC member must meet an out-of-pocket EPIC deductible based on their previous

year's income before they receive EPIC co-payments.

- Deductible Plan members are grouped into two categories:
  - Low Band
  - High Band

Low Band

EPIC Deductible members with incomes:

- $20,0001 to $23,000 (single)
- $26,001 to $29,000 (married/joint)

Will receive Medicare Part D premium assistance from EPIC up to the basic benchmark amount ($72.34 in 2025).

High Band

EPIC Deductible members with incomes:

- $23,0001 to $75,000 (single)
- $29,0001 to $100,000 (married/joint)

Members are responsible for paying their Medicare Part D premium each month.

Members' EPIC deductible will be reduced by the annual benchmark cost of a Medicare Drug Plan ($868 in 2025).

EPIC and Low-Income Subsidy (LIS)/Extra Help

EPIC members who also qualify for Low Income Subsidy (LIS) or "Extra Help" from Medicare can save significantly more on their Medicare Part D costs. Extra Help is a federal program that helps lower most of a member's prescription cost. EPIC will assist members in applying for Extra Help. The benefits of having EPIC together with Extra Help include:

- EPIC fees are waived for members with Extra Help.
- Additional savings on generic drugs ($4.90 in 2025) lowered to $3.00; brand name drugs ($12.15 in 2025) lowered to $3.00.
- Medicare pays Part D premiums up to the benchmark and in 2025 is $72.34; EPIC can also pay up to an additional benchmark amount after Medicare premium subsidy.

EPIC and Low-Income Subsidy (LIS) and Medicare Savings Program (MSP) Initiative:

- Members will be receiving either the Request for Additional Information (RFAI) or the Medicare Savings Program (MSP) application based on the income eligibility for these programs and what the member's reported income is.
- Non-responders will result in EPIC cancellation.
- If a member signs the "consent to withdraw" on the MSP application and returns it, they will automatically be cancelled out of the EPIC program.
- If cancelled out of the EPIC program for not responding to the letter/application or withdrawing from the MSP process, they will have to complete the EPIC application and whichever application they failed to complete to become an "active" EPIC member.

How to Apply for EPIC:

Older adults can apply for EPIC at any time of the year in the following ways.

- Mailing a completed application to:

  EPIC
  PO Box 15018
  Albany, NY 12212-5018

- Faxing the completed application to:

  518-452-3576

- Request an EPIC application from the EPIC Helpline (800-332-3742); visit https://www.health.ny.gov/health_care/epic/application_contact.htm to download and print an application; complete an online request for EPIC to mail out an application; or ask their pharmacists for an application.

EPIC Identification (ID) Card

EPIC members will receive an EPIC ID card following a successful enrollment. Members should present both their EPIC and Medicare Part D ID cards at the pharmacy when filling prescriptions. Members who receive their prescriptions through mail order programs must contact the mail order pharmacy and update their profile with their EPIC membership information for billing purposes.

Contact Information

Telephone:

EPIC Helpline: 1-800-332-3742 (M-F 8 am to 5 pm)
TTY: 1-800-290-9138
Provider Helpline: 1-800-634-1340
Fax: 518-452-3576

Mailing Address:

EPIC
PO Box 15018
Albany, New York 12212-5018

Email: NYSDOHEPIC@primetherapeutics.com
EPIC Outreach: NYSEPICOutreach@primetherapeutics.com
Website: http://www.health.ny.gov/health_care/epic/

Low Income Subsidy Program
Extra Help

The Extra Help program, also known as the Part D Low-Income Subsidy (LIS), helps people with limited income and resources reduce, or cut, their Part D costs (drug coverage). It aids with the cost of a beneficiary's prescription drugs, like deductibles and copays. A beneficiary can apply for Extra Help at any time before or after they enroll in Part D. A beneficiary will get Extra Help automatically if they receive:

- Full Medicaid coverage.

- Assistance with paying their Part B premiums from a Medicare Savings Program (MSP) within their state. This automatic process is referred to as "deeming."

- Supplemental Security Income (SSI).

A beneficiary will get a letter about their Extra Help benefit, explaining how much they will pay and their new Medicare drug plan, if they do not have one already.

If a beneficiary does not automatically get Extra Help, they can apply through Social Security at https://www.ssa.gov/medicare/part-d-extra-help.

Benefits of Extra Help

The Extra Help program (LIS) offers the following benefits:

- Pays for the Part D premium up to a state-specific benchmark amount. The 2025 benchmark amount is $72.34. NYS currently has three benchmark plans in 2025.

- Lowers the cost of prescription drugs.

- Gives beneficiaries a Special Enrollment Period (SEP) once per month to enroll in a Part D plan or to switch between plans. This SEP is designed specifically for enrollment into a stand-alone Part D plan. A beneficiary may not use it to enroll into a Medicare Advantage plan with drug coverage.

- Eliminates any Part D late enrollment penalty the beneficiary may have incurred if they delayed Part D enrollment.

Best Available Evidence

The U.S. Centers for Medicare and Medicaid Services (CMS) created the Best Available Evidence (BAE) policy to address incorrect Low-Income Subsidy (LIS)/Extra Help 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.

Assisting Beneficiaries with 'Extra Help' Issues at Pharmacy

If the beneficiary's Extra Help is not acknowledged at the pharmacy, your first step as a counselor is to contact Medicare and the plan using your SHIP Unique ID to verify eligibility and help resolve the issue. The plan must accept proper faxed documentation and update the beneficiary's LIS information at the pharmacy. It can take anywhere from 2 to 24 hours for the pharmacy's system to be updated.

Acceptable Documentation:

- An Extra Help award letter from the Social Security Administration.
- A copy of the beneficiary's Medicaid card, with eligibility date.
- A print-out from the state enrollment file showing Medicaid status during a month after June of the 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.

The automatic process of enrolling Medicare Savings Program beneficiaries into Extra Help – referred to as deeming – can take up to 4-6 weeks. The New York State Department of Health sends an electronic file every month to CMS. It may take time for the lower co-pay status to be recognized at the pharmacy. Beneficiaries will be reimbursed the difference for any prescription filled from their effective date. The Extra Help Chart can be found on the following page.

Extra Help Chart (for illustrative purposes). Find a downloadable version at: https://www.medicarerights.org/fliers/Help-With-Drug-Costs/Extra-Help-Chart.pdf?nrd=1

MEDICARE RIGHTS CENTER
Getting Medicare right

Extra Help
Income and Asset Limits 2025

Extra Help is a federal program that lowers your Medicare prescription drug coverage (Part D) monthly premium and any deductible, coinsurance, and copayments. You may qualify if you have limited income and assets.

You have	Your eligibility requirements	Your costs
Medicare only	**Income Limit** Individual: $1,976/month Couple: $2,664/month **Asset limit[2]** Individual: $17,600 Couple: $35,130	$0 premium[3] and deductible $4.90 generic copay $12.15 brand-name copay
Medicare and a Medicare Savings Program (MSP) only	You are automatically enrolled in Extra Help	
Medicare and Medicaid with or without an MSP	You are automatically enrolled in Extra Help	$0 premium[3] and deductible **Income above 100% FPL** $4.90 generic copay $12.15 brand-name copay **Income below 100% FPL[4]** $1.60 generic copay $4.80 brand-name copay

[1] Income limits are based on the Federal Poverty Level (FPL), which changes every year in February or March. Until the Federal Poverty Level (FPL) is released, eligibility is based on the 2025 income limits. Limits are higher for each additional relative living with you for whom you are responsible. Income and asset limits on this chart are rounded to the nearest whole dollar. There is a $20 income disregard (factored into the income limits above) that the Social Security

[2] Asset limits include $1,500 per person for burial expenses.

[3] You pay no premium if you have a basic Part D drug plan with a premium at or below the Extra Help premium limit for your area.

[4] You pay $0 copays if you are institutionalized or receive home and community-based services.

 Helpline: 800-333-4114 www.medicareinteractive.org

Medicare Savings Program (MSP)

The Medicare Savings Program (MSP) program can assist people with limited income in paying for some of their Medicare premiums. Depending on their income, the MSP may also pay for other cost-sharing expenses. There is no resource test for the MSP programs. Additional benefits of enrolling in an MSP include:

- Allowing a beneficiary to enroll in Medicare Part B outside of usual enrollment periods.
- Eliminating a beneficiary's Part B late enrollment penalty if they have one.
- Automatic enrollment in the Extra Help program.

In New York State there are three MSPs: Qualifying Individual (QI), Qualified Medicare Beneficiary (QMB), and the Qualified Disabled and Working Individual (QDWI).

The Qualified Medicare Beneficiary Program (QMB):

- Pays for the Medicare Part A and/or Part B premiums.
- Medicare providers should not bill QMB beneficiaries for any Medicare-covered services that they receive.
- 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 QMBs.
- Does not offer retroactive premium reimbursement.
- Is effective the first of the month after application.

Eligibility is based on income:

- For a single individual, the monthly income threshold is $1,820 (includes $20 disregard).
- For a couple, the monthly income threshold is $2,453 (includes $20 disregard).

The 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 the same year as the effective date.

Eligibly is based on income:

- For a single individual, the monthly income threshold is $2,446 (includes $20 disregard).
- For a couple, the monthly income threshold is $3,299 (includes $20 disregard).

The Qualified Disabled and Working Individual (QDWI):

- Pays for the Medicare Part A premium only, not Part B.
- The applicant must be a disabled worker under age 65 who lost Part A benefits because of return to work. The applicant must not be eligible for Medicaid.

The Qualified Disabled and Working Individual (QDWI) income eligibility is based on 200% of the federal poverty level.

Medicare Savings Program Budgeting

Earned income includes wages, salary and earnings from self-employment. Unearned income includes: gross Social Security (before the Part B premium is deducted); pensions, including disability pensions; and income from retirement accounts only if asset pays out regularly. Some common MSP income disregards are interest earned on checking or savings accounts, food stamps, or cash assistance.

Health insurance premiums can also be used as a disregard. This includes Medigap, Medicare Advantage, Part D premiums that are “above the benchmark” amount, Long Term Care Insurance, Union Health Fund and Dental Insurance. For additional information on MSP budgeting, please refer to http://health.wnylc.com/health/entry/99/.

Household Sizes

In 2010, the New York State Department of Health modified its rules so that all married individuals will be considered a household size of two. See the Department of Health General Information System (GIS) message (10 MA 10) at https://www.health.ny.gov/health_care/medicaid/publications/gis/10ma010.htm. (This applies regardless of whether the spouse is also aged, blind or disabled).

There are two exceptions to the household size rule if:

- The couple is not living together.
- One spouse is permanently residing in a nursing home.

MSP Application

Note: The MSP application should be printed on **legal size paper** as it is too large for 8x11 print. If printed on 8x11 paper, it may be difficult for an applicant to complete the application properly.

The Medicare Savings Program application may be found on the NYS Department of Health website at the following webpage:

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

Please see the following two pages to view the current MSP application.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicare Savings Program Application

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

APPLICANT

First Name, Middle Initial, Last Name			Home Phone Number ( )		
Home Address Street	Apt. No.	City	State	Zip Code	County

Is this a shelter? ☐ Yes ☐ 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 M, F, X	Gender Identity** (Optional)	Social Security Number	Race/Ethnicity Group (See codes below)
Self	/ /			– –	
Spouse	/ /			– –	
Child*	/ /			– –	
Child*	/ /			– –	

*If under 18 years of age

**Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.

Gender Identity Codes: M-Male, F-Female, N-Non-Binary or Non-Conforming, X-X, T-Transgender, D-Different Identity: Describe your Identity in space provided.

Race/Ethnic Group Codes: B-Black or African American, W-White, H-Hispanic or Latino, †A-Asian or Pacific Islander, I-American Indian or Alaskan Native, †P-Native Hawaiian or other Pacific Islander, U-Unknown, O-Other.

†If you have selected A-Asian, or P-Native Hawaiian or Pacific Islander please see below information on Other AAPI.

‡Other Asian American/Pacific Islander (optional) - Please identify your AAPI subgroup. Subgroups within this community include, but are not limited to: Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan, Taiwanese, Native Hawaiian, Samoan, Tongan, Guamanian or Chamorro, Marshallese, Fijian, and 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? ☐ Yes ☐ No	Effective Date	Do you have Medicare Part B? ☐ Yes ☐ No	Effective Date

Spouse's Medicare Number (From Red and Blue Medicare Card)			
Does your spouse have Medicare Part A? ☐ Yes ☐ No	Effective Date	Does your spouse have Medicare Part B? ☐ Yes ☐ 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			Relationship
City	State	ZIP Code	Phone Number ( )

INSTRUCTIONS

PLEASE TYPE OR PRINT LEGIBLY

COMPLETE THE APPLICATION

Be sure to answer all the questions. If you are married and living with your spouse, you must complete both the "Self" and "Spouse" questions on the application (even if the spouse is not applying for the MSP).

SIGN AND DATE THE APPLICATION

If both spouses are applying, both must sign the MSP application.

INCLUDE THE FOLLOWING VERIFICATION DOCUMENTS

Please review this list and submit the documents that you will need to provide in order for the Medicaid Program to determine if you are eligible for MSP. If you are requesting retroactive reimbursement of your Medicare premiums, you must send proof of income for the previous three-months. If there is an applying spouse, the spouse must also provide documentation.

- A photocopy of the front and back of your **Medicare card**.
- **Proof of income:** Paycheck stubs, letter from employer, income tax return, award letter for any unearned income benefit such as social security, unemployment, or veteran's benefit, or letter from renter, boarder or tenant.
- **Health insurance premiums that you pay other than Medicare:** Letter from employer, premium statement, or pay stub.
- **Proof of date of birth:** State driver's license, U.S. birth certificate, permanent resident card ("green card"), or NYS Benefit Identification Card.
- **Proof of residence:** Lease/letter/rent receipt with your home address from your landlord, driver's license (if issued in the past 6 months), utility bill (gas, electric, phone, cable, fuel or water), government ID card with address, property tax records or mortgage statement, or postmarked envelope or postcard (cannot use if sent to a P.O. Box).
- If you are not a U.S. citizen, you must provide documents indicating your current immigration status.

Mail the application and required documentation to your local Department of Social Services (LDSS) or Human Resource Administration (HRA). To find the address in your county: http://www.health.ny.gov/health_care/medicaid/ldss.htm.

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying for the Medicare Savings Program. **PAYMENT OF YOUR MEDICARE PREMIUM IS A MEDICAID BENEFIT.**

PENALTIES

I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid benefits or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility.

CHANGES

I agree to immediately report any changes to the information on this application.

SOCIAL SECURITY NUMBER (SSN)

If you are applying for the Medicare Savings Program, you must report your SSN. The laws requiring this are: 18NYCRR Sections 351.2, 360-1.2, and 360-3.2(j)(3); 42USC 1320b-7. SSNs are used in many ways, both within the local social services districts and also between local social services districts and federal, state, and local agencies, both in New York and in other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if absent parents can get health insurance for applicants, to see if applicants can get child support and to see if applicants can get money or other help.

CERTIFICATION OF CITIZENSHIP & IMMIGRATION STATUS

I certify, under the penalty of perjury, by signing my name on this application, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. I understand that information about me will be submitted to the United States Citizenship and Immigration Services (USCIS) for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid program.

NON-DISCRIMINATION NOTICE

This application will be considered without regard to race, color, sex, disability, religious creed, national origin, or political belief.

CERTIFICATION

In signing this application, I swear and affirm that the information I have given or will give to the Department of Social Services as a basis for Medicaid is correct. I also assign to the Department of Social Services any rights I have to pursue support from persons having legal responsibility for my support and to pursue other third-party resources. I understand that Medicaid paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program, please sign your name below:

I consent to withdraw my application:

Applicant Signature	Date

<table>
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<tr><td colspan="4">Date Eligibility Determined By Worker</td><td colspan="4">Date Eligibility Approved By</td></tr>
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Medicaid
Medicare and Medicaid Beneficiaries

Medicaid renewals reminder

The Centers for Medicare & Medicaid Services (CMS) announced that all states must complete all public health emergency (PHE) unwinding activities, including Medicaid renewals, by 2026.

New Yorkers with Medicaid or a Medicare Savings Program (MSP) who receive a renewal packet **must complete and return their renewals by their listed deadline**. Packets should include new cover letters warning recipients that they must submit this renewal. **Those who do not will lose their Medicaid and/or MSP and must reapply**.

Landmark Eligibility Increases

The New York State budget included landmark increases to Medicaid and MSP eligibility, effective January 1, 2023.

For the first time, the Medicaid income levels for individuals will be set at 138% Federal Poverty Level (FPL) for individuals in the non-MAGI Medicaid populations (which includes individuals 65+ as well as individuals who are disabled with Medicare and individuals who are blind with Medicare). Since this is the same income limit that is used for MAGI Medicaid, many Medicaid recipients will be able to keep Medicaid with no spend-down once they become enrolled in Medicare and are shifted to non-MAGI Medicaid.

The 2025 income and resource standards for Medicaid can be found at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/25ma03_att1.pdf.

Resources

Certain resources do not count toward the above limits, such as household goods, an automobile, pre-paid funeral agreements for the applicant and their spouse, and a burial fund of up to $1,500 for the applicant or spouse.

Also, the applicant's and their spouse's retirement accounts are exempt as long as they are taking regular distributions from these accounts. IRA distributions are required even if they are not yet of the age where the IRS requires them. These distributions are countable as income.

The applicant's home has an equity limit only if the applicant is seeking home- and community-based services (HCBS). HCBS includes managed long-term care (MLTC), adult day care, personal care, consumer-directed assistance through the local Medicaid agency, or waiver programs. For a single person seeking MLTC or

HCBS services (who does not have a spouse, minor or disabled child living with them) the equity limit for the home is $1,097,000 (2025).

The Empire Justice Center and Western New York Law Center provide a downloadable Excel spreadsheet to calculate the 2025 spend-down at http://health.wnylc.com/health/download/829/.

Individuals Newly Eligible for Medicaid

Some individuals may have had MSP only, not Medicaid, but now are eligible for Medicaid under the 2025 income limits. In these cases, those who want Medicaid must submit an entire Medicaid application and Supplement A to their local Medicaid office. They cannot simply request "rebudgeting." Those who had QI-1 or SLIMB and now want to upgrade to QMB must submit the one-page MSP application at DOH-4328 and may not simply request rebudgeting. Please look for more about this roll-out at http://www.wnylc.com/health/news/90/.

Individuals who are determined to have excess income need to spend-down a certain amount of money by incurring medical expenses each month, or paying-in the spend-down to the local Medicaid agency, to activate Medicaid. Alternatively, they may deposit their excess income into a Supplemental Needs Trust or pooled trust to eliminate the spend-down. Fortunately, fewer very low-income people will have a spend-down because of the increased Medicaid income limits – now at 138% of the federal poverty level (FPL).

Look-Back Penalties

The Medicaid Look-Back for skilled nursing facilities remains at 60 months (five years). Transfers made within the five years before admission to a nursing home and application for nursing home Medicaid may cause a "transfer penalty" period based on the amount transferred. This means that Medicaid will not pay for nursing home care during the penalty period.

The lookback and transfer penalties still do not 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. However, in future years, a 30-month lookback on all HCBS services will apply (including MLTC, immediate need, and the Assisted Living Program) due to a change in the law in 2020. This change has been delayed because of COVID rules. According to DOH, the change is not expected to take effect until 2025 for new Medicaid applications. More information is at: http://health.wnylc.com/health/news/85/#lookback.

Part A and Part B Coordination with Medicaid and Billing

- Medicare's Coordination of Benefits will now automatically cross-over and submit an unpaid bill to Medicaid.

- A doctor who accepts Medicaid must always accept Medicare assignment on claims.

QMB and Medicaid

Both Medicaid and the Qualified Medicare Beneficiaries (QMB) program supplement Medicare coverage by paying or preventing (in the case of QMB) out-of-pocket Medicare cost-sharing (co-insurance and deductibles). Medicaid can only pay for medical claims to providers who accept Medicaid. Medicaid additionally provides services and supplies not covered by Medicare or after Medicare benefits are exhausted.

In 2022, the New York State budget increased the QMB income limit from 100% to 138% of the Federal Poverty Level effective January 1, 2023. This limit is the same as the new income limit for Medicaid. (Those with incomes above 138% of the Federal Poverty Level can spend down for Medicaid but their income is too high for QMB.) Now that the income limit is the same for Medicaid and QMB, all dual-eligibles who do not have a spend-down are eligible for QMB. Some people have only QMB but not Medicaid because their assets are above the Medicaid asset limit.

How Much does Medicaid Pay of Medicare Part B Coinsurance?

Medicaid does not always pay the full 20% Part B coinsurance. How much Medicaid pays depends on the approved Medicare and Medicaid rates for the service, and whether the consumer is in a Medicare Advantage Plan. See http://www.wnylc.com/health/entry/94/#How%20%much%20will%20Medicaid%20pay.

Balance Billing Protections

Both QMB and Medicaid beneficiaries have protections from being billed for the 20% Medicare co-insurance and deductibles, but they are slightly different.

Medicaid beneficiaries who do not have QMB are protected from balance billing only if the doctor/provider accepts Medicaid. QMB beneficiaries cannot be balance billed even if the provider does not accept Medicaid. See more about balance billing protections for QMB at http://health.wnylc.com/health/entry/94/.

The doctor may be able to refuse to accept a client for future visits.

Qualifying for QI-1 Medicare Savings Program

Medicare beneficiaries whose income is too high for Medicaid or QMB may qualify for the QI-1 Medicare Savings Program. Please refer to the Medicare Savings Program in this resource guide to learn more about this program.

The QI-1 limit has increased from 135% to 187% of FPL. Someone with income that is too high for Medicaid and whose assets are under the Medicaid limit must choose between having QI-1 or Medicaid with a spend-down. They cannot have both.

Billing Issues

Medicaid Billing Concerns can be addressed to:

- Computer Science Corp – 1-800-343-9000.

Pooled Income Trusts and Eligibility

A Pooled Income Trust can be used to bring income below the QMB or QI-1 limit, as well as below the Medicaid limit. Counselors should always screen dual-eligible beneficiaries for QMB or QI-1 so they should not be responsible for the Part B premium (nor responsible for Medicare cost-sharing in the case of QMBs).

New Dual Eligibles Who Had Medicaid Before Enrolling in Medicare

New York has begun auto-enrolling Medicare-eligible individuals who have Medicaid through New York State of Health (NYSoH) into the Qualified Medicare Beneficiary (QMB) MSP. This population previously received a monthly reimbursement check for their Part B premiums via the Medicare Insurance Premium Payment (MIPP) program. Instead, MSP enrollment has been automated for this population. Going forward, most beneficiaries with NYSoH Medicaid who become eligible for Medicare will no longer need to go through the MSP application process.

Medicare Advantage Plans and Medicare Advantage Dual-Special Needs Plans

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 crossover as with Original Medicare.

Medicaid Advantage Dual-Special Needs Plans (Dual-SNP) are designed to work specifically with a dual-eligible beneficiary.

Default Enrollment of Medicaid Recipients Who Are Newly Ineligible for Medicare

New Medicare beneficiaries with Medicaid that enrolled in a “mainstream” Medicaid managed care plan may be “default enrolled” into an aligned Dual-SNP. This change went into effect starting with those newly eligible for Medicare in April 2021.

For individuals not receiving Medicaid, personal care or CDPAP services from their mainstream plan, some are default enrolled into an “IB-DUAL” plan (Integrated

Benefit – Dual) plan. This is basically a new name for when a mainstream Medicaid managed care plan and a Dual-SNP are aligned, meaning that both plans are operated by the same insurance company, and the state and CMS have approved the plan to use the default enrollment process.

If the individual receives Medicaid personal care, CDPAP, or private duty nursing services from their mainstream managed care plan, they may be default enrolled into a Medicaid Advantage Plus (MAP) plan, which is a hybrid of a Dual-SNP, MLTC and mainstream Medicaid managed care plan all in one. Default enrollment into a MAP only occurs when then the insurance company that operates the mainstream managed care plan also offers a MAP that is approved to use default enrollment.

Under "default enrollment," the Medicaid recipient receives a notice 60 days before they will be automatically enrolled in the Dual-SNP and "IB-DUAL" plan or MAP plan, with the right to "opt out" and select their preferred Medicare and Medicaid coverage. Those who receive home care services from their managed care plan may opt out of MAP and select an MLTC plan instead.

Default enrollment is only being used by some plans in certain counties. A list of those specific counties may be found on DOH's new website on integrated care for dual eligibles: https://www.health.ny.gov/health_care/medicaid/redesign/duals/index.htm.

Under the dropdown for "IB-DUAL" is a chart identifying which plans have been approved for default enrollment in each county. The MRC Default Enrollment Fact Sheet can also be referenced at https://medicareinteractive.org/pdf/default-enrollment-NYS.pdf.

Dual-Eligibles and Medicare Advantage Premiums

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

Dual-Eligibles and Prescription Drug Coverage

All dual-eligible beneficiaries will be automatically deemed (enrolled) into Extra Help. A dual-eligible beneficiary must have Medicare Part D. Medicaid no longer covers prescription drugs for dual-eligibles, except for some over-the-counter drugs and supplies. 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 will have no drug coverage. If a dual-eligible has creditable drug coverage through an employer or union or spouse, they are not automatically enrolled into a Part D plan. This is to prevent duals from jeopardizing their employer or union coverage.

Medicaid no longer covers prescriptions for dual-eligible beneficiaries, even if the 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). 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 New York State Medicaid for dual-eligible patients.

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.

Medicaid also does not cover compound prescriptions for the dually eligible population. Patients and providers should consult the appropriate Medicare Part D or Medicare Advantage Prescription Drug (MA-PD) plan for coverage of compounded prescriptions for medically accepted indications. Medicaid will cover compounded prescriptions for New York State Medicaid beneficiaries who are not Medicare eligible.

If a dual eligible beneficiary or LIS recipient is billed at 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's systems are updated. The pharmacist or beneficiary must contact or fax a document to the plan showing that the individual has Medicaid, an MSP, or Extra Help. See the Best Available Evidence Policy in the Medicare Part D section. This most commonly happens for someone newly approved for Medicaid or MSP who is not yet coded as having Extra Help.

When a dual-eligible or MSP beneficiary goes to the pharmacy and there is no evidence of a Part D plan, but there is clear evidence of both Medicare and Medicaid or MSP, the pharmacist is required to bill the Limited Income Net program (LINET). A 31-day supply of the drug will be provided. See the LINET/Point of Sale in the Medicare Part D section.

A dual-eligible beneficiary may switch plans once per month to enroll in a stand-alone Part D plan with Original Medicare or an integrated Dual-SNP. They may also switch plans: Once they are notified of a change of LIS or dual status, if they are admitted to a nursing home, or if they were assigned by CMS or their state (e.g., auto-assigned, reassignment, passive enrollment).

Spend-down to Medicaid

If a person's income is above the Medicaid limit, the client may qualify for Medicaid by incurring medical bills in an amount that is equal to or greater than the monthly spend-down. To calculate the spend-down, the spouse's income also counts if they live together, even if the spouse is not applying, unless the spouse does a "spousal refusal." (There is a rare exception – if the spouse is under age 65 and not disabled, their income does not count if it is under the "allocation amount" of $633/month in 2025. In that case, just like in spousal refusal, use the income limit for a single not a couple.)

The spend-down must be met each month to have ongoing Medicaid coverage using a bill incurred in the current month. A bill incurred and paid in the current month can be used to meet the spend-down for a period of up to six months.

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 that allows them to use past bills (incurred and paid in the three calendar months prior to the month of application or in the month of application). These past bills can be used to meet the spend-down for up to six months beginning in the month of application or retroactively up to three calendar months prior to the month of application. The applicant may also be reimbursed for these paid bills once the spend-down is met if the provider accepts Medicaid.

Unpaid Bills and Spend-down

Unpaid medical bills may be used to meet the spend-down as long as they are viable, meaning a provider can sue to collect the money (generally a six-year time limit). These bills may be used to meet the spend-down beginning in the month of application or retroactively up to three calendar months prior to the month of application. Unlike paid bills, there is no limit on the length of time these bills can be used to meet the spend-down.

Example

For example, if Mary has a $200/month spend-down and had a $4,000 dental bill five months before she applies for Medicaid, the bill can be used to meet the spend-down for 20 months, beginning in the month of her application or, at her option, retroactively three calendar months before she applies.

Medicaid, however, is authorized in maximum periods of six months. She will be initially authorized for six months of Medicaid using $1,200 of the bill. The next two six-month authorizations will each use up $1,200 more of the bill until a total of $3,600 has been exhausted. The next and last $400 authorization will be for 2 months, unless she has additional current bills.

Counties have different procedures for how to make sure the unpaid bills continue to be applied to renew the authorization after the first six-month period. NYC HRA requires advocacy to make this happen.

Other Considerations

- 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 of the spouse can be used to meet the client’s spend-down, and bills for any dependent child under age 21 can be used toward spend-down.

- 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 July or later, they will receive Extra Help for the rest of that year and the following calendar year.

Which Expenses Count

The following types of expenses can be used to meet the spenddown:

- Deductibles and coinsurance for Medicare, Part D or other private health insurance.

- 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.

- EPIC or ADAP. The amount EPIC or ADAP pays (not just the client's co-payment) counts toward the spend-down. This includes EPIC or ADAP payment during the three months before the month that the client applies for Medicaid.

- Hospital bills. To cover an inpatient hospital stay, even for just one night, Medicaid requires the individual to meet six months of spend-down instead of one month. This is true for Medicaid to cover the Medicare Part A hospital deductible. For example, Pat is hospitalized for one night and has a spend-down of $200. The Part A hospital deductible is $1,676 in 2024. Pat is responsible for six months of the spend-down ($1,200). Medicaid will pay $476. However, if Pat has QMB, QMB/Medicaid will pay the entire Part A hospital deductible.

Ways to Reduce or Eliminate the Spend-down

There are various strategies to reduce or eliminate the spend-down, as described below. More info on these and other strategies can be found at http://www.wnylc.com/health/entry/222/.

Spousal Impoverishment Income Protections

The expense of nursing home care, which ranges from $8,000 to $25,000 a month or more, can rapidly deplete the lifetime savings of elderly couples. In 1988, Congress enacted provisions to prevent "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 enable community spouses to keep enough of the couple's combined income and resources to live with independence and dignity. Spousal impoverishment protections apply to married nursing home residents after the 29th day of admission. These provisions have been extended to community spouses of individuals receiving:

- Medicaid managed long term care (MLTC) – but only after the "sick" spouse is enrolled in the plan. When the applicant first applies for Medicaid in order to enroll in MLTC, they must use "spousal refusal." Then, once enrolled, they may request spousal impoverishment budgeting from the local Medicaid office.

- "Immediate Need" personal care or Consumer Directed Personal Assistance Program (CDPAP) services – unlike MLTC, spousal impoverishment budgeting is available upon the initial application for Medicaid if applying for Immediate Need.

- Traumatic Brain Injury or Nursing Home Transition & Diversion waivers (known as Home and Community Based Services, or HCBS, waivers).

When a "sick" spouse is in a nursing facility or is in one of the three long-term care programs listed above, an assessment of both spouses' individually owned and joint resources is made. The couple's resources, regardless of ownership, are combined for purposes of assessing the spousal impoverishment resource allowance. The same exemptions apply as in the community, listed at the beginning of this section. The home is exempt if the community spouse is residing there, regardless of its value.

The Medicaid spouse may keep countable resources up to the single resource limit used in the community ($32,396 in 2025). If the Medicaid Spouse has more countable resources solely in his/her name or held jointly with the "community spouse," the Medicaid spouse may transfer resources that exceed the resource limit of $32,396 to the community spouse. Transfers to anyone else – with exceptions – may cause a "transfer penalty."

The community spouse may keep $74,820 of the couple's combined resources, apart from exempt resources described above. If the community spouse has more than $74,820, then he or she may keep up to one-half of the couple's combined resources up to $157,920 (2025). If the couple has more resources, they should consult an elder law attorney for other options, as excess countable resources may be considered available to the Medicaid spouse. These options 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 investment income if the spouse's income is otherwise below the minimum monthly maintenance needs standard. Once resource eligibility is determined, any resources belonging to the community spouse are no longer considered available to the spouse in the medical facility.

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) of $3,948/month in 2025, 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 MMMNA is calculated after applying allowable deductions. If the community spouse's income exceeds the MMMNA, 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 MMMNA, 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 $633/month (2025) and enough to pay any Medigap or other health insurance premiums.

If the client is married and the spouse does not need or qualify for Medicaid, the client may still apply if the spouse refuses to make income and resources available. With spousal refusal, the budget is considered "single." The county may have the right to sue the "refusing" spouse for support. Each county has different policies. Also note that if/when the new "lookback" for home-and community-based care eligibility begins, no earlier than 2025, the spouse's resources must be documented for the 30-month lookback period. This is true even if the spouse does a spousal refusal. This is because transfers made by the spouse during the lookback period can trigger a transfer penalty that disqualifies the applying spouse from eligibility for home care or other HCBS services. See more about the new lookback above.

Special Income Deduction for People Who Left a Nursing Home or Adult Home and Enrolled in or Remained 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 or remains enrolled 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 at http://www.wnylc.com/health/entry/212/. Clients cannot use both this housing deduction and "spousal impoverishment" budgeting – they must pick one or the other.

Special Deductions from Income as a Work Incentive

If a person who is age 65+, blind, or disabled works, the first $65 of monthly gross earned income is disregarded. Then half of the remaining earned income is disregarded. If their spouse is working and the spouse is not using spousal refusal, their earned income uses the same disregards. If the applicant or recipient is disabled and under age 65, they also have a higher income limit of 250% of the Federal Poverty Level. This is called the Medicaid Buy-In for Working People with Disabilities (MBI-WPD). See http://health.wnylc.com/health/entry/59/. While older adults do not presently benefit from that higher income limit, they do get the special earned income disregard.

For other special budgeting rules (for disabled adult children, etc.), see http://health.wnylc.com/health/entry/222/.

Pooled Income Trusts to Reduce or Eliminate the Spend-Down and Qualify for QMB

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 that varies between trusts, 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 a request for a disability determination. That request is referred to the New York State Disability Review Unit, which will request 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/.

In 2025, many recipients will be able to reduce the amount they contribute to pooled trusts – or even close the trusts altogether – because of the increase in Medicaid income limits.

- **TIP**: An individual does not need to wait until the local Medicaid agency re-budgets their spend-down using the increased 2025 income limits in order to reduce their contribution to the trust. If the spend-down is correctly calculated, the individual may adjust the contribution now. When they go through the "unwinding" renewal described above, if the budget calculation was correct, the Verification of Deposits in the reduced amount should be sufficient to offset the spend-down. Download the Excel document to calculate spend-down at http://health.wnylc.com/health/download/829/. Note that this calculator uses the 2024 FPLs.

See also the Fact Sheet on Pooled Trusts to Reduce the Medicaid Spend-down at http://www.wnylc.com/health/entry/6/.

New York Independent Assessor Program for Eligibility to Receive Medicaid Personal Care or CDPAP services

The New York Independent Assessor Program (NYIAP) replaced the Conflict Free Eligibility & Evaluation Center for those seeking Medicaid personal care or CDPAP services. (See https://nyia.com/en.) NYIAP must now also be used when seeking services through the local Medicaid office, whether through Immediate Need or through the regular process for those who are exempt from MLTC (in the OPWDD, NHTD or TBI waiver or receiving home hospice care). NYIAP must also be used for a “mainstream” managed care member to request personal care or CDPAP.

For more information see:
http://health.wnylc.com/health/entry/253/

View a webinar on NYIAP at:
https://www.youtube.com/watch?v=kgEpSmt9528

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. However, it is possible for a Medicaid only individual to enroll in MLTC if they require certain services not included in the mainstream managed care plan benefit package. 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, dentistry, optometry, nursing home care, as well as physical, speech, and occupational therapies.

Coordination of Medicare Benefits and MLTC

Having an MLTC plan does not affect a beneficiary's Medicare. This means that Original Medicare or the Medicare Advantage Plan remains the beneficiary's primary payer, paying first for the care the beneficiary receives from hospitals, primary care doctors, and specialists. The beneficiary's Medicare prescription drug coverage also remains unchanged.

Dual-eligible individuals (having both Medicare and Medicaid) who are age 21 and older and who are assessed as needing community based long term care services for more than 120 days must enroll in MLTC in order to receive those services.

Dual-eligible nursing home residents who are age 21 and older and determined to need permanent nursing home placement must join an MLTC plan.

The following may voluntarily enroll in MLTC:

- Dual-eligible individuals, age 18 to 20, who have been assessed as eligible for nursing home level of care at time of enrollment and also assessed as needing community based long term care services for more than 120 days; and

- Non-dual-eligible individuals, age 18 and older, who have been assessed as eligible for a nursing home level of care at time of enrollment and also assessed as needing community-based long term care services for more than 120 days.

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

Resources

Individuals can call the state DOH complaint line at 1-866-712-7197. More information may be found at: http://www.health.ny.gov/health_care/managed_care/mltc/aboutmltc.htm.

Medicare Marketing Rules

The Medicare Communications and Marketing Guidelines are rules that private insurance companies that sell Medicare plans must follow when promoting their products. Independent agents and brokers selling plans must be licensed by the state, and the plan must tell the state which agents are selling their plans.

People representing Medicare plans **are not permitted to**:

- Ask for a beneficiary's personal information (like Medicare, Social Security, bank account, or credit card numbers) over the phone unless it is needed to verify membership, determine enrollment eligibility, or process an enrollment request. Plans do not need a beneficiary's personal information to give a quote.

- Come to a beneficiary's home uninvited to sell or endorse anything.

- Call a beneficiary unless they are already a member of the plan.

- Require a beneficiary to speak to a sales agent to get information about the plan.

- Offer beneficiaries cash (or gifts worth more than $15) to join their plan or give them free meals during a sales pitch for a Medicare health or drug plan.

- Ask a beneficiary for payment over the phone or online. The plan must send the beneficiary a bill.

- Sell a beneficiary a non-health related product, like an annuity or life insurance policy, during a sales pitch for a Medicare health or drug plan.

- Set an appointment to meet with a beneficiary about their plan unless the beneficiary first agrees to do so. During the appointment, the agent or broker may only try to sell the beneficiary products that the beneficiary has agreed to discuss.

- Talk to a beneficiary about plans in areas where the beneficiary receives health care, such as an exam room, hospital patient room, or at a pharmacy counter.

- Market their plans or enroll a beneficiary during an educational event such as a health fair or conference.

Rules when Meeting with an Agent

If a beneficiary is meeting with an agent, the agent must follow all of the above rules for selling Medicare plans along with some specific rules for meeting with beneficiaries.

During the meeting, Medicare plans and people who work with Medicare **are permitted to**:

- Give a beneficiary plan materials.
- Tell a beneficiary about plan options and how to get more plan information.
- Give a beneficiary an enrollment form.
- Collect a beneficiary's completed enrollment form.
- Distribute business cards for a beneficiary to share with friends, family, etc.

During the meeting, Medicare plans and people who work with Medicare **are not permitted to**:

- Charge a fee to a beneficiary to process their enrollment into a plan.
- Steer or direct a beneficiary into a particular plan.
- Communicate incorrect information about a plan type or use inappropriate statements (i.e. Stating that a certain plan is "the best" or "highest ranked").
- Tell a beneficiary about other plan options that they have not agreed to discuss, unless the beneficiary specifically asks about them. (To discuss these options, the beneficiary must first complete a separate appointment form.)
- Pressure a beneficiary to join a plan by saying things such as "you have to join this plan," or "you will not have coverage next year."
- Ask a beneficiary to provide names, phone numbers or addresses of friends, family, etc. so that the agent may attempt to sell plans to them.
- Ask a beneficiary to sign an enrollment form before they are ready to join.

After the meeting:

- The plan should contact a beneficiary to confirm that they want to join the plan, and that the beneficiary understands how the plan works.
- The agent who assists a beneficiary with joining a plan may call the

beneficiary to discuss other plan options.

Reporting a Possible Violation

- For CMS NYRO marketing concerns and questions, contact NYROMarketingQuestions@cms.hhs.gov.

- More information can be found at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.

Medicare Complaints

A beneficiary may wish to file a complaint if they have concerns about the quality of care or other services that they have received from a Medicare provider, prescription drug plan, or a Medicare Advantage plan. NYSOFA HIICAP, Medicare and the plan can aid the beneficiary in navigating the complaint process.

Case Resolution Process

The case resolution process involves the following steps:

1. Work with the Medicare Advantage Prescription Drug (MAPD) Plan or the Prescription Drug Plan (PDP) first. Some plans have a dedicated SHIP line. If so, you can use your SHIP Unique ID number to obtain information.

2. If you are unable to resolve the case by working directly with the plan, use your SHIP Unique ID to contact Medicare through the dedicated SHIP line listed below. This will allow you to obtain more information, such as the beneficiary's current insurance status, Part A & Part B effective dates, their enrollment history, or their low-income subsidy status.

Medicare's Dedicated SHIP number: 1-888-647-6701

Once you are connected, an automated voice will prompt you to enter your Unique ID, then choose from one of the options listed below.

Option 1: General Medicare Issues (including Part D)
Option 2: Part A Issues
Option 3: Part B Issues
Option 4: Medical Equipment Issues
Option 5: To Dis-enroll from a Part D Plan

If you are unable to resolve the case after contacting the plan and Medicare, please reach out to NYSOFA HIICAP for case work assistance. You can reach us by phone or email. Please note that emails should not contain personal identifying information (PII). Once NYSOFA receives the case information, NYSOFA HIICAP will:

- Follow up with a phone call directly to the coordinator or counselor to obtain additional details for case resolution. In some instances, NYSOFA HIICAP can resolve the case without escalation.

- Follow up and request that a Complaint Tracking Module (CTM) form be completed for escalation to the plan or U.S. Centers for Medicare & Medicaid Services (CMS).

- The CTM form may be found on **page 64**. Please be sure to complete all fields within the form as this information is imperative to further investigating each case. Please send CTM forms by **fax only** as these forms generally contain PHI and sensitive information. The NYSOFA HIICAP fax number is 518-486-2225.

- If a CTM is filed, the plan will work directly with NYSOFA HIICAP to provide updates and information; NYSOFA HIICAP will update the local coordinator and/or counselor once a resolution is reached.

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 1-800-Medicare or the state Department of Finance online at https://www.dfs.ny.gov/complaint.

Other Resources

New York State Senior Medicare Patrol (SMP): SMP's mission is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. You can report suspected problems to NY SMP at 800-333-4374.

Office of the Medicaid Inspector General (OMIG): For Medicaid Fraud allegations, contact the Office of the Medicaid Inspector General (https://omig.ny.gov) at BMFA@omig.ny.gov or toll-free at 877-873-7283.

Complaint Tracking Module Form (for illustrative purposes). Please contact NYSOFA to request a copy of the form.

NEW YORK STATE OF OPPORTUNITY. Health Insurance Information, Counseling and Assistance Program

SHIP State Health Insurance Assistance Program

Complaint Tracking Module Form (CTM)

Date of incident

Complaint Information:

Name of County	
Name of Counselor	
Direct phone number	
Email	

Beneficiary Information:

Name:	
Medicare number:	
Date of Birth:	
Address:	
Phone number:	

Who is the complaint against?

Check one	Type of plan	Plan Contract #
	Medicare Advantage Prescription Drug Plan (MAPD)	
	Prescription Drug Plan (PDP)	

Nature of complaint:

____

____

____

End result: What is beneficiary requesting? Enrollment into what plan- provide contract #

____

____

____

Issue level

	Immediate Need:	**complaints to be resolved within 2 calendar days**
	Urgent Need:	**complaints to be resolved within 7 calendar days.**
	Non-issue:	**complaints to be resolved within 30 calendar days.**

Fax Completed form to NYSOFA HIICAP (518)-486-2225

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
CVS Caremark	CVS Caremark Plans	866-490-2098
Express Scripts	Express Scripts	800-846-4917
Humana	Humana	888-666-2902
SilverScript	SilverScript Prescription Plans	888-831-3049
WellCare Health Plans	All Medicare Advantage and Prescription Drug Plans	866-675-8574

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

Plan Finder

The Medicare Plan Finder is an online searchable tool on the www.medicare.gov website that allows users to compare Medicare plan options, including Medicare Advantage plans, Medicare Part D plans, and Medigap supplemental policies.

Plan Finder includes a listing of prescription drugs that is updated on a regular basis. However, it should be noted, Plan Finder does not include each and every drug that is covered under Medicare:

- If you can't find the drug, contact the 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 (ex. test strips, lancets, needles), so these items may not be applied when using this tool to search for plans.

Several factors affect drug prices: drug dosage and quantity selected, pharmacy selection, the subsidy level of a beneficiary, as well as the actual timing of a drug purchase. Plan Finder provides estimated pricing for what a beneficiary will pay at a given pharmacy. If the dosages and frequencies entered on Plan Finder are different than those prescribed to a beneficiary, then they may end up paying prices that do no match up to those estimated in Plan Finder. For this reason, it is important to utilize the exact dosages, frequencies and quantities when searching for drugs on Plan Finder.

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 may 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 Health Insurance Claim Number (HICN), Effective Date, Last Name, Date of Birth (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, the enrollment has been saved. This confirmation number should be written down, or the confirmation page should be printed, so that the counselor and/or the beneficiary may have a record of the enrollment. In the event that a beneficiary may need to cancel an enrollment, they may need to call the plan directly or 1-800-MEDICARE and may need the enrollment confirmation number when doing so. You may also use the "Email Your Confirmation" button to send an email to yourself, or the beneficiary, containing all the information on the confirmation page.

Technical Problems

Counselors must first contact 1-800-Medicare to report a Plan Finder problem. The customer service representative (CSR) will log your issue. If assistance is still needed, please follow-up with NYSOFA HIICAP.

HIICAP Reporting

The State Health Insurance Assistance Program (SHIP) Tracking and Reporting System (STARS) is the nationwide, web-based data system that facilitates the reporting of SHIP grantee activities to the federal government. See https://stars.acl.gov.

STARS is a federal data system that is managed and housed by Booz Allen Hamilton. STARS offers a modernized user experience for SHIPs as they work to provide Medicare beneficiaries with information, counseling, and enrollment assistance.

Compliance with the reporting requirement is a term and condition of each Area Agency on Aging or its subcontractor who receives a HIICAP and/or MIPPA grant award(s). Federal funding requires SHIPs to use the SHIP Tracking and Reporting System (STARS). HIICAP reporting is web-based and secured. Booz Allen Hamilton, the SHIP Technical Assistance Center, and NYSOFA provide technical assistance to area agencies as needed via training, manuals, online help, and phone contact.

Continued funding for this program is contingent upon accurate quality data. Quality data:

- Provides local, state, and national sponsors with statistics to justify continued support.
- Documents the valuable services that you have performed.
- Helps to maintain the highest quality of services.

User Profiles

All HIICAP Coordinators, Counselors, Volunteers, Subcontractors and MCCAP Agencies who will be reporting HIICAP and/or MIPPA activities must be registered in the federal reporting system STARS. User profiles in the STARS system are referred to as “team member” profiles and consist of nineteen required fields to register. Counselors and volunteers will need to provide their HIICAP Coordinator with the required information, which will then be forwarded to NYSOFA for the creation of the team member profile. Once a team member profile has been created by NYSOFA, the team member will receive a username and temporary login information (credentials) from STARS (Booz Allen Hamilton, the federal reporting contractor).

Once registered, you can sign in at https://stars.acl.gov and enter client data and activities by using the Beneficiary Contact Form (BCF), the Group Outreach and Education Form (GOEF), or the Media Outreach and Education Form (MOEF). Each local HIICAP counselor should use hard copies of these forms to ensure all data fields are captured and reporting is accurate. The BCF, GOEF and the MOEF should be printed and provided to each counselor so that they can record each counseling session, as well as every outreach and education event. The recorded data should then be entered into the online Reporting System. The BCF, GOEF and the MOEF forms are available for download through the SHIP TA Center: https://www.shiphelp.org/.

Locked Accounts and Direct Entry Users

The STARS system may automatically lock a user from logging in after 120 days of reporting inactivity. While NYSOFA HIICAP staff may be able to reactivate a lapsed account, the lapsed user may also need to reach out to Booz Allen Hamilton at boozallenstarshelpdesk@bah.com to unlock their accounts and receive their log-in credentials.

Booz Allen Hamilton has implemented a 90-day password change policy. Direct entry users will need to change their passwords every 90 days. If more than 90 days has passed since a user has logged into STARS, they may use the Forgotten Username or Password feature at https://stars.acl.gov.

Multi-Factor Authentication

As of 5/17/2025, a multi-factor authentication process has been implemented for STARS access, by sending a unique code to the user's email address that is only valid for five minutes. STARS only allows a user's email address that is pre-established in STARS, as the sole means of authentication. If a user's email address has changed, and must be updated within the STARS system, please contact NYSOFA HIICAP for further assistance.

Importance of Timely Data

NYSOFA HIICAP regularly monitors the data captured by STARS. Counselors are advised to set a specific time aside each day/week to enter data so that you don't fall behind in recording your information. STARS data is utilized to fulfill real time legislative and administrative requests. **Please do not wait until the reports are due. Maintaining accurate records is very important.**

The SHIP Tracking and Reporting System (STARS) consists of the following forms:

1. The Beneficiary Contact Form (BCF)
2. The Group Outreach and Education Form (GOEF)
3. The Media Outreach and Education Form (MOEF)
4. The Activity Form
5. The Training Form

Beneficiary Contact Form (BCF)

The BCF records all beneficiary contacts. Contacts can be made over the phone, in person at the office or in a home or facility, via postal mail, e-mail, web-based platforms such as Skype, or by fax. Enter all beneficiary contact data under the Tracking Inbox, New Beneficiary Contact tab (https://stars.acl.gov). Counselors are encouraged to collect as much demographic information (age, sex, income, ethnicity) as possible with each counseling session.

The Group Outreach and Education Form (GOEF)

The GOEF captures the type and number of group outreach activities such as Booths/Exhibits (Health Fairs, Senior Fairs or Community Events), Enrollment Events, and Interactive Presentations to the Public (In-Person, Video Conference, Web-based Events, Teleconference, Pre-recorded webinars with follow-up contact info), as well as the topics covered and their target audiences. To input data, go to Tracking Inbox, under the New Group Outreach and Education tab (https://stars.acl.gov). The Group Outreach Form should be completed at least once per quarter.

The Media Outreach and Education Form (MOEF)

The MOEF captures the type and number of media outreach activities such as Billboard, Email, Magazine, Newsletter, Newspaper, Radio, Social Media, Television, Website, and other media source, as well as the topics covered and their target audiences. To input data, go to the Tracking Inbox, under the New Media Outreach and Education tab (https://stars.acl.gov). The Media Outreach Form should be completed at least once per quarter.

The Activity Form

The Activity tab associated with each saved team member profile in STARS is how you access the Activity Form in STARS. It allows team members to enter their own time spent on activities not captured on the other STARS forms, and it allows users with access to others' team member forms to enter that time on their behalf, if desired. Options include Administrative Support, Program Management, and Other SHIP Activities. The Activity Form is counted in the annual Resource Report. The Activity Form should be completed at least once per quarter.

The Training Form

The Training form is designed to capture specific orientation, training, and testing activities for SHIP (HIICAP) and MIPPA team members. The Training form is accessed under the Tracking Inbox to capture in-person, virtual/online trainings and self-paced training conducted on the local level. Examples include CMS Medicare Updates, SHIP TA training (i.e., Medicare Minutes, STARS training), orientation and locally developed HIICAP Training. As established, NYSOFA will report attendance at the Spring and Fall Regional Medicare Updates Trainings, the two-day Coordinators' training and the monthly coordinator calls, as well as time spent completing the annual HIICAP Exam. The training form should be completed at least once per quarter.

Please note: It is important to obtain all data and complete each section of all forms for input into the STARS reporting system.

SHIPs must submit data to STARS monthly. The schedule below displays the timeline by which data should be entered directly into STARS.

Month Effort Occurred	Data Entry Due Dates for Efforts
April	May 31
May	June 30
June	July 31
July	August 31
August	September 30
September	October 31
October	November 30
November	December 31
December	January 31
January	February 28
February	March 31
March	April 30

Data Entry Timelines

- Beneficiary Contacts, Group Outreach and Education Events, Media Outreach and Education Events must be entered by the end of the following month.

- Data from April 1 to March 31 of the following calendar year must be entered by April 30 of that following year (12-month period). For example, data collected between April 1, 2025 and March 31, 2026 should be entered by no later than April 30, 2026.

- Late data for the current contract year will not be accepted after the April 30 due date.

NYSOFA will contact all Agency Area on Aging Directors for data that has not been reported timely, as late data will cause counties to lose credit for work submitted after reporting deadlines.

Resource Report

The Resource Report is used to gather metrics on the various demographics of users in the STARS system. The report provides a summary of active users and logs the amount of time spent completing various activities during a given timeframe. The Resource Report is now a system generated report which pulls data from team member profiles and all forms entered.

The annual reporting period for the Resource Report is from April 1 to March 31. All Beneficiary Contacts, Group Outreach and Education events and Media Outreach and Education Events should be entered into STARS by April 30.

Note: The below applies to those who utilize the Statewide Client Data System for reporting.

Correcting Errors

In order for records to meet pre-validation and be sent to the Federal SHIP Tracking and Reporting System (STARS) through an Application Programming Interface (API) model, the STARS queue should be processed frequently by each local program to address error messages and validate records for STARS submission. API submission is scheduled by NYSOFA HIICAP. Reporting deadlines are sent out monthly via e-mail to HIICAP coordinators. It is important to process your STARS queue to comply with reporting requirements. If you fail to process your STARS queue, it will result in late data. Below is guidance on how to correct error messages in the STARS queue:

How to correct errors:

1. To see records with errors, select Error from the status dropdown.
2. Enter or select the date range you are searching for.
3. Click Go.
4. Click on the Name to navigate to the record to correct. The identified error will display on the record.
5. Once you have corrected the error, continue to Save or Save & Exit until you return to the queue.
6. Once error(s) are fixed, click Process Queue. A message ‘Complete’ should then appear in red font. Once this message appears, click Go to refresh the changes. Note: Corrected records will now display on the pending queue.

Additional Considerations

Currently the API endpoint will not accept the following data elements:

- SHIP Team Member Profiles (to be created by NYS HIICAP staff only)
- File Attachments
- Content updates

Therefore, while all client contacts and outreach data entered into the Statewide Client Data System will be uploaded into STARS through the API process, all data associated with SHIP Team Member Profiles, File Attachments, and Content Updates need to be directly entered into STARS.

- Beneficiary (Client Contact) Additional Session
- Group Additional Team Members (Presenters)
- Media Additional Team Members (Presenters)
- SHIP Team Member Activity Form
- Training Form

Additional Info

NYSOFA provides ample notice and reminders when reports are due. You can find Web and Data Technical Support as noted below:

STARS Technical Support
Booze Allen Hamilton
Booz Allen STARS Help Desk
boozallenstarshelpdesk@bah.com

You can also find additional tools and training resources related to STARS through the SHIP National Technical Assistance Center (SHIP TA Center) at https://www.shiphelp.org/.

The SHIP TA Center provides webinar training, technical assistance, and written instructions for using STARS. Contact the SHIP TA Center STARS team at stars@shiptacenter.org and 877-839-2675.

Uninsured

Some important tips when working with the uninsured:

- 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.

Additional Resources

AIDS Drug Assistance Program (ADAP): To qualify, a person must be low-income, uninsured, or underinsured with HIV/AIDS. In-state, call 1-800-542-2437 or 1-844-682-4058; out of state, call (518) 459-1641. Visit https://www.health.ny.gov/diseases/aids/general/resources/adap/.

Accessia Health (formerly Patient Services Inc.): Helps pay for medication, provides health insurance premium and copay assistance, navigates health insurance plans, and provides legal advice for people who have been diagnosed with chronic illnesses. To apply, call 1-800-366-7741 or visit https://www.patientservicesinc.org/.

Community Health Advocates (CHA): This program is similar to HIICAP. CHA is a great resource if you would like to refer a person, especially for those who do not qualify for Medicare. Contact cha@cssny.org or 1-888-614-5400 or visit 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 the following links:

- https://www.opm.gov/retirement-services/
- https://www.opm.gov/healthcare-insurance/healthcare/
- 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 at 1-855-268-2822 or visit https://www.goodrx.com/.

Great Expressions Dental Centers (formerly American Dental Centers): This is a membership group. The 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. Must use their dental offices. Family rates are available. Call 1-888-764-5380 or visit https://www.greatexpressions.com/special-offers/spp-home.

Health Economics Group, Inc. Dental Network Card Program: Offers referral services to dentists in specific areas who will accept lower fees as full payment for people without dental insurance. To find out more information, call 1-800-666-6690 (outside the Greater Rochester area), 585-241-9500 (in the Greater Rochester area), or https://www.hegpartners.com/dental.

The HealthWell Foundation: When health insurance is not enough, this organization helps to fill the gap by assisting with drug copays, medical copays, health insurance premiums, deductibles, coinsurance, and out-of-pocket expenses. To find out if someone qualifies, call 1-800-675-8416.

LawHelp.Org/NY: Helps low-income New Yorkers solve legal problems such as 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): A national non-profit advocacy organization that provides patient assistance and financial resources for lifesaving and life-extending treatments to people in need. To find out more information, call 1-877-968-7233.

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. A person 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): This medication assistance program 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 website. To apply, call (800) 999-6673 or visit https://rarediseases.org/.

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: This program helps hard-working low-income households to afford short-term emergency expenses. For more information, please visit https://www.modestneeds.org or call 1-844-667-3776.

Patient Advocate Foundation Co-Pay Relief: Provides direct copayment assistance for pharmaceutical products to insured Americans who financially and medically qualify. To find out more information and to see if someone qualifies, call 1-866-512-3861.

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 can 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.pfizerrxpathways.com/.

Pharmaceutical Company Patient Assistance Programs (PhRMA): Free or heavily discounted Rx for limited duration (often 90 days). A person must have internet access to search and can search by drug name, company or class. For a directory of programs, contact 1-800-931-8691 or visit: www.rxassist.org, https://www.myrxadvocate.com/, or http://www.needymeds.org/.

Rx Outreach: No age limit. No enrollment fees. Household income for 2022 must be at or below 400% of the Federal Poverty Level. An individual must have an annual income of $54,360 or less, and a couple must have an annual income of $73,240 to be eligible. To find out more information, call 1-800-769-3880, 1-888-796-1234 or http://rxoutreach.org/.

TRICARE: Military retiree program for people who have served for at least 20 years. Must be registered with Defense Enrollment. No enrollment fees and low-cost Rx. To find out more information, call TRICARE East for NYS residents at 1-800-444-5445 or for Rx benefits contact Express Scripts, Inc. at 1-877-363-1303.

VA Health Benefits Service Center: For assistance, 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) through the New York State Commission for the Blind: Find information on programs for older adults at 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 or www.lighthouseguild.org.

Eyecare America: Provides eye exams and up to one year of care to U.S. 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.aao.org/eyecare-america.

New Eyes for the Needy: Purchases new prescription eyeglasses for children and adults facing financial hardship who are living in the United States. 1-973-376-4903, www.new-eyes.org.

Local Department of Social Services Offices

Albany County DSS – 518-447-7300 (Main number) 518-447-7492 (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 Suite 6010, Olean, New York 14760-1101

Cayuga County DSS – 315-253-1011
County Office Building, 160 Genesee St, Auburn, New York 13021-3433

Chautauqua County DSS – 716-661-8200
110 E. 4th Street, Jamestown, New York 14701

Chemung County DSS – 607-737-5302
425 Pennsylvania Avenue, Elmira, New York 14902

Chenango County DSS – 607-337-1500
5 Court Street and 14 West Park Place, Norwich, New York 13815

Clinton County DSS – 518-565-3300
13 Durkee St, Plattsburgh, New York 12901-2911

Columbia County DSS – 518-828-9411
25 Railroad Avenue, 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 Street Suite 4, 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 Street, 8th Floor, Buffalo, New York 14202-3959

Essex County DSS – 518-873-3441
7551 Court Street, PO Box 217, Elizabethtown, New York 12932-0217

Franklin County DSS – 518-481-1888
184 Finney Blvd., Malone, New York 12953

Fulton County DSS – 518-736-5600
4 Daisy Lane, PO Box 549, Johnstown, New York 12095

Genesee County DSS – 585-344-2580
5130 East Main St, Batavia, New York 14020

Greene County DSS – 518-719-3700, 518-943-3200, or 1-877-794-9268
411 Main Street Suite 238, Catskill, New York 12414

Hamilton County DSS – 518-648-6131
139 White Birch Lane, PO Box 725, 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 – 315-785-3000 or 315-782-9030
250 Arsenal Street, Watertown, New York 13601

Lewis County DSS – 315-376-5400
5274 Outer Stowe Street, 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
133 North Court Street, Building 1, PO Box 637, Wampsville, New York 13163

Monroe County DSS – 585-753-6298, 585-753-6998, or 585-753-2750
111 Westfall Rd, Rochester, New York 14620-4686

Montgomery County DSS – 518-853-4646
County Office Building, 64 Broadway, PO Box 745, Fonda, New York 12068-0745

Nassau County DSS – 516-227-8519
60 Charles Lindbergh Blvd., Uniondale, New York 11553-3656

New York City – 718-557-1399
Human Resources Administration
150 Greenwich Street, New York, New York 10007

Niagara County DSS – 716-439-7600 or 716-278-8400
20 East Avenue, Lockport, New York 14094

Oneida County DSS – 315-798-5700
800 Park Avenue, Utica, New York 13501-2981

Onondaga County DSS – 315-435-2928
John H. Mulroy Civic Center, 421 Montgomery St, Syracuse, New York 13202-2923

Ontario County DSS – 585-396-4060, (Outside County 1-877-814-6907)
3010 County Complex Drive, Canandaigua, New York 14424-1296

Orange County DSS – 845-291-4000
11 Quarry Road, Box Z, 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 Street, Mexico, New York 13114

Otsego County DSS – 607-547-4355 or 607-547-1700
County Office Building, 197 Main St, Cooperstown, New York 13326-1196

Putnam County DSS – 845-808-1500
110 Old Route 6 #2, Carmel Hamlet, New York 10512-2110

Rensselaer County DSS – 518-266-7970
127 Bloomingrove Drive, Troy, New York 12180

Rockland County DSS – 845-364-3100 or 845-364-3040
50 Sanatorium Road, Building L, Pomona, New York 10970

Saratoga County DSS – 518-884-4140
152 West High St, Ballston Spa, New York 12020

Schenectady County DSS – 518-388-4470
797 Broadway, Schenectady, New York 12305-2704

Schoharie County DSS – 518-295-8334
County Office Building, 284 Main Street, 2nd Floor, PO Box 687, Schoharie, New York 12157

Schuyler County DSS – 607-535-8303
323 Owego St, Unit 3, Montour Falls, New York 14865

Seneca County DSS – 315-539-1800
1 DiPronio Drive, Waterloo, New York 13165-0690

St. Lawrence County DSS – 315-379-2111
6 Judson Street, Canton, New York 13617-1197

St. Regis Mohawk Tribe – 518-358-2272
71 Margaret Terrance Memorial Way, Akwesasne NY 13655

Steuben County DSS – 607-664-2000
3 East Pulteney Square, Bath, New York 14810

Suffolk County DSS – 631-854-9930 or 631-854-9700
3085 Veterans Memorial Highway, Ronkonkoma, New York 11779-8900

Sullivan County DSS – 845-292-0100
16 Community Lane, Liberty, New York 12754

Tioga County DSS – 607-687-8300 or 607-687-8302
1062 State Route 38, PO Box 240, Owego, New York 13827

Tompkins County DSS – 607-274-5680
320 West Martin Luther King/State Street, Ithaca, New York 14850

Ulster County DSS – 845-334-5000
1061 Development Court, Kingston, New York 12401-1959

Warren County DSS – 518-761-6300
Human Services Building, 1340 State Route 9, Lake George, New York 12845-9803

Washington County DSS – 518-746-2300
Municipal Center, 383 Broadway, Building B, Fort Edward, New York 12828

Wayne County DSS – 315-946-4881
77 Water Street, PO Box 10, Lyons, New York 14489-0010

Westchester County DSS – 914-995-3333
112 East Post Road, 5th Floor, White Plains, New York 10601-4201

Wyoming County DSS – 585-786-8900
466 North Main Street, Warsaw, New York 14569-1080

Yates County DSS – 315-536-5183
County Office Building, 417 Liberty Street, Penn Yan, New York 14527-1118

Health Insurance Information, Counseling and Assistance Program

SHIP State Health Insurance Assistance Program

NEW YORK STATE

Office for the Aging
Health Insurance Information, Counseling and Assistance Program

Two Empire State Plaza
Albany, NY 12223-1251

Kathy Hochul, Governor
Greg Olsen, Acting Director

www.aging.ny.gov