



**Office for
the Aging**

A Quick Reference Guide to HIICAP 2016-2017

*For HIICAP Counselors Only
Not for Public Distribution*

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HIICAP Help Line: 1-800-701-0501
Website: www.aging.ny.gov/HealthBenefits



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

Valid Medicare Card and Suffixes

The codes following a Social Security number indicate the type of benefits you are entitled to. The Social Security number followed by one of these codes is often referred to as a claim number and they are only assigned once you apply for benefits. These letter codes may appear on correspondence that you receive from Social Security or on your Medicare card. They will NEVER appear on a Social Security number card

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JOHN DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
MALE

IS ENTITLED TO
HOSPITAL (PART A) **01-01-2007**
MEDICAL (PART B) **01-01-2007**

SIGN HERE → _____

CPT codes and descriptors are only copyright 2003 American Medical Association (or such other dare publication ofCP7).

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

MEDICARE – Part A

Co-Insurance/Deductible (2016 - Per Benefit Period):

Hospital ~

Day	1	\$1,288 deductible per benefit period - Paid upon admission in a hospital
Day	2-60	\$ 0
Days	61- 90	\$ 322 per day
Days	91+	\$ 644 per day

Skilled Nursing Facility ~

\$0 for the first 20 days of each benefit prior
\$161.00 per day for days 21-100 of each benefit period
All costs for each day after day 100 of the benefit period

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.

If a person enters a hospital or SNF after their benefit period has ended (more than 60 days after they left), a new benefit period begins. There is a deductible for each benefit period. There is no limit to the number of benefit periods or to the length of an individual benefit period. More information on SNF co-insurance can be found on the following page.

Eligibility:

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

Age 65 and Older:

- you or your spouse (or former spouse) had at least 10 years (or 40 calendar quarters) of employment in which you paid Social Security taxes;
- would be entitled to Social Security benefits based on your spouse's (or divorced spouse's) work record, and that spouse is at least 62 (your spouse does not have to apply for benefits in order for you to be eligible based on your spouse's work); or
- Receive Social Security or railroad retirement benefits;
- are not getting Social Security or railroad retirement benefits, but you have worked long enough to be eligible for benefit;
- Worked long enough in a Federal, State, or local government job to be insured for Medicare; or

Under Age 65:

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

Enrollment:

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

Premium (2016):

\$ 0	40 or more working quarters
\$226.00/month	30-39 quarters of working quarters
\$411.00/month	Less than 30 quarters



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

MEDICARE - Part B

Co-Insurance: 20% of Medicare approved amount after annual deductible.

Deductible: \$166.00

Eligibility:

- You are Age 65 and a United States (U.S.) citizen or have resided in the U.S. continuously for at least 5 years as of the point you are enrolling for Part B (or premium Part A) and have been lawfully admitted for permanent residence.
- If you are under the Age of 65, you must meet the same criteria noted above (for persons Age 65 and up) and have a disability and are receiving Social Security Disability Insurance (SSDI) for more than 24 months, or diagnosed with End-Stage Renal Disease, or Amyotrophic Lateral Sclerosis (ALS).
- If a person does not purchase Part B when first eligible, they may face a penalty. (See Late Enrollment Penalty section on the reverse side of this page.)

Enrollment Guidelines: Enroll through Social Security at 1-800-772-1213

A person does not need to join Part B if they, or their spouse, is working and has employer health insurance.



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

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

Effective Dates:

- If you enroll in Part B in the 3 months before you turn 65, your coverage begins the 1st of the month you turn 65.
 - If you enroll in the month of your birthday, coverage begins the first of the following month.
 - If you enroll in the month after, coverage begins two months later. If you enroll in the 2nd or 3rd months after your birthday, it begins 3 months later.
- **Special Enrollment Period (SEP):** A person has 8 months to enroll into Part B once their employment ends, or their creditable health insurance coverage ends.
 - If you enroll while covered, or during the first full month after coverage ends, your Medicare Part B will start on the first day of the month you enroll. (You can also delay the start date for coverage until the first day of any of the following 3 months.)
 - If you enroll during any of the 7 remaining months, your Medicare Part B coverage begins the month after you enroll.



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

Late Enrollment Penalty:

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

How to file for Equitable Relief (or Appeal) for Enrollment or Late Enrollment Penalty:

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

Premium:

The chart below shows the Part B monthly premium amounts based on income.

If Your Yearly Income is:		2016 Part B Premiums:
File Individual Tax Return	File Joint Tax Return	
\$ 85,000 or less	\$170,000 or less	\$121.80
\$ 85,001 - \$107,000	\$170,001-\$214,000	\$170.50
\$107,001- \$160,000	\$214,001-\$320,000	\$243.60
\$160,001- \$214,000	\$320,001-\$428,000	\$316.70
Above \$214,000	Above \$428,000	\$389.80

How to file for Equitable Relief on Premiums:

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

Equitable Relief: Navigating the process

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

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

Who can obtain equitable relief?

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

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

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

How can you request equitable relief?

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

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

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

Problems with equitable relief

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

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

[Print on professional stationery, if possible]

[Date]

Social Security Administration

[Address of local office]

Re: Medicare Part B Premium Penalty

Beneficiary: **[Name]**

SSN: **[Social Security Number]**

Dear Sir/Madam:

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

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

[Explain why you did not enroll in Part B when first eligible. Be as detailed as possible regarding any misinformation you received from Social Security or other federal agency or federal agent such as a Medicare Private plan including names and dates.]

42 U.S.C. § 1395p(h) states:

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

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

Sincerely,
[Your name]
[Your title]

Attachments: **[List any attachments]**

MEDICARE - Part C Medicare Advantage Plans

Medicare Advantage Plans (MAs) are offered in many areas of the country by private companies that sign a contract with Medicare. These plans must provide Medicare-covered benefits and may offer additional benefits that Medicare doesn't cover, such as prescription discounts, vision or dental services. People may have to pay an additional monthly premium for the extra benefits.

Eligibility:

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

Enrollment Guidelines:

Please refer to page 21 ~ Medicare Enrollment Period section in this guide.

Medicare Advantage Plan Choices:

Medicare Managed Care Plans (similar to HMOs) – You see doctors and hospitals in the plan's network. A primary doctor coordinates your health care. Referrals are usually required to see a specialist. These plans have been part of Medicare the longest.

Medicare Preferred Provider Organization Plans (PPO) – You can see any doctor, but it costs less to see doctors in the plan's network. Some plans don't require referrals.

Private Fee for Service Plans (PFFS) – Beginning in 2011, Private Fee-for-Service (PFFS) plans (specifically, non-employer/union sponsored PFFS plans) are required to have networks of providers like other managed care plans. PFFS plans operating in regions of the country where there are fewer than two other network-based Medicare Advantage (MA) plans will not have to meet this requirement.

Medicare Specialty Plans (also known as Special Needs Plans, (SNPs) – These plans are only available in certain areas. They provide all Medicare health care for people with Medicare special needs, such as persons on Medicaid, have End-Stage Renal Disease (SRD), and/or reside in an institution.

Medicare Medical Savings Account (MSA) – Is a Medicare private health plan that combines a high-deductible health plan with a medical savings account. The plan will only pay for covered services once you have spent a specific out-of-pocket deductible.

NOTES:

What is a Managed Long Term Care Plan?

What is a MLTC Plan?

A managed long term care (MLTC) plan is a special type of Medicaid managed care plan that provides long term care and certain other Medicaid services.

Each Plan has its own group of home care agencies, professionals and other providers. This group is the Plan's **network of providers**. After you join a Plan, you must get your services from the Plan's providers.

MLTC plans provide person-centered Plans of Care, which means that you will have an active role in planning your services. You will have a **Care Manager** who will get to know you and talk with you about your service needs. Your Care Manager will assist you and anyone else you want to involve, in developing a **Plan of Care** that meets your specific needs.

There are three different types of Plans.

1. MLTC only ("MLTC")
 - Plan provides Medicaid LTC package ONLY
2. Medicaid Advantage Plus
 - A Medicare Advantage plan that includes Medicaid LTC package
3. Program for All-Inclusive Care for the Elderly (PACE)
 - A Medicare Advantage plan that includes Medicaid LTC package

Who Must Join a Plan?

You must join a Plan if:

- You have both Medicaid and Medicare
- You need home care, adult day health care, or other long term care for more than 120 days (four months)
- You are age 21 or older.
- You live in a mandatory MLTC county.

I Get Home Care Now. Do I Have to Join a Plan?

Yes – you must join a Plan if you received a letter from **New York Medicaid Choice** telling you to join a Plan by a certain date. The Plan you select will take over your care and approve your services. If you do not select a Plan, the Medicaid Program will assign you to one of the **MLTC Medicaid Plans** in your borough or county.

How Long Do I Stay with a Plan?

A Plan must approve your services for as long as you qualify for home care and other long term care services. You decide what Plan you want. You can also ask to change Plans at any time.

Who Does Not Have to Join a MLTC Plan

The following people are not required to join a Managed Long Term Care Plan, even if they live in a mandatory county. They may join a Plan if they want:

- Native Americans
- Adults age 18-20, who need more than 120 days of community-based long term care
- Adults who are nursing home eligible and enrolled in the Medicaid Program for the working disabled. People receiving the following services cannot join a Managed Long Term Care Plan. In some cases, you may leave your program to join a Plan.
 - People enrolled in an Assisted Living Program
 - People enrolled in the Traumatic Brain Injury (TBI) or Nursing Home Transition & Diversion waivers
 - People participating in the Consumer Directed Personal Assistance Program (CDPAP)
 - People receiving hospice services or who are residents of a psychiatric or residential care facility or nursing home
 - People who have a developmental disability and receiving care in a facility, in the community or through a waiver program, and those who have similar needs
 - People who live in Family Care Homes licensed by the Office of Mental Health
 - Residents of alcohol and drug abuse residential treatment programs
 - People who have Medicaid eligibility only for tuberculosis-related services
 - People who are uninsured and receiving breast and cervical cancer services and those who are under age 65 and eligible for the early detection program
 - People who have Medicaid eligibility only for breast and cervical cancer services
 - People who are eligible for family planning expansion program
 - People with less than 6 months of Medicaid eligibility
 - Eligible for emergency Medicaid only

For more information, visit:

http://www.health.ny.gov/health_care/managed_care/mltc/aboutmltc.htm

1-888-401-6582

State DOH Complaint Lines-

MLTC 1-866-712-7197 or MMC 1-800- 206-8125

MEDICARE - Part D

Medicare Part D Benchmark Amounts:

2013	2014	2015	2016	2017
\$43.22	\$37.23	\$36.94	\$39.73	\$40.99

Best Available Evidence (BAE):

BAE is a policy to make immediate up-to-date cost-sharing pricing at the pharmacy.

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

Acceptable Documentation:

Extra Help (LIS) Eligible Beneficiaries:

- A letter of award from the Social Security Administration.

Medicaid Eligible Beneficiaries:

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

Note: Most local DSS letters are not considered State documentation. NYSOFA has been working with CMS on this concern as most awards are generated by the County DSS in NYS.

Medicare Savings Program Beneficiaries:

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

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



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

Coverage Gap/Donut Hole:

The gap starts when a person's TOTAL cost of prescriptions (what the beneficiary and the plan) has paid for covered drugs. In 2016, the coverage gap begins when total drug costs reach \$3,310

As a result of Health care Reform, Medicare beneficiaries who reach the coverage gap can expect the following changes:

Year	Generic Benefit	Brand Benefit	Brand Discount
2016	42	5	50
2017	49	10	50
2018	56	15	50
2019	63	20	50
2020	75	25	50
TOTAL	75% Coverage For Both Generic and Brand Drugs		

The entire amount of the drug will be applied toward the beneficiary's True Out-Of-Pocket expenses (TROOP)!

Catastrophic Coverage:

When a person's Total Out-Of-Pocket Costs for covered drugs (only what the BENEFICIARY has paid) reaches \$4,850 in 2016. A beneficiary will pay five percent of the cost of each covered drug, or a co-pay of \$2.95/\$7.40, whichever is greater.

Deductible:

2016 Deductible \$360

2017 Deductible \$400

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

Eligibility:

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

Enrollment Guidelines:

Enrollment into Medicare Part D is optional for most people. A person usually has 63 days to enroll into Medicare Part D when first eligible. If a person does not enroll during this time, they may be liable for a Late Enrollment Penalty.

5 Star Special Enrollment Period: December 8th until November 30th

**** NYS does not have any 5 star plans for 2016.

- People can switch to a 5-star Medicare Advantage plan (with or without drugs), a 5-Star Medicare Prescription Drug plan at any time during the year.
- People currently enrolled in a plan with a 5-Star overall rating may also switch to a different plan with a 5-Star overall rating.
- Enrollment is effective on the first day of the following month.

Annual Disenrollment Period: January 1st – February 15th (ADP)

- During this time, you have one opportunity to switch back to Original Medicare.
- A person may pick-up a PDP, regardless of whether they had previous coverage.
- A person will not be able to switch Medicare Advantage Plans.
- A person will not be able to purchase a Medicare Advantage Plan.

Annual Election Period (AEP): October 15th until December 7th

Special Enrollment Period (SEP): Allows a person to enroll into a Part D plan due to certain circumstances.

(SEP chart can be found on page 29)

(See Medicare Enrollment Periods in this Guide)

Late Enrollment Penalty:

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

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

2014 National Average Premium = \$32.42

2015 National Average Premium = \$33.13

2016 National Average Premium = \$34.10

2017 National Average Premium = \$35.63

For example, the average national premium in 2016 was \$34.10 a month. If you delayed enrollment for five months, your monthly penalty would be \$1.70. This penalty will be added to the person's plan premium. ($\$34.10 \times 1\% = \$0.341 \times 5 = \$1.70$)



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

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

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

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

Limited Income Newly Eligible Transition Program (LINET):

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

For Pharmacists - How To Submit Claim to the Limited Income NET Process:

Enter the claim through your claims system in accordance with the Limited Income NET Program Payer sheet, which can be found at:

<https://www.humana.com/pharmacy/pharmacists/linet>

BIN = 015599 (as of 1/1/12)

PCN = 05440000

Cardholder ID = Beneficiary HICN

Group ID may be left blank

Patient ID = Medicaid ID or Social Security Number

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

For HIICAP Counselors Only! – Additional Resources:

MedicareLINET@cms.hhs.gov
1-866-934-2019 eligibility review

Computer Science Corporation (CSC) – NYS Medicaid Payer
For problems at the pharmacy with Medicaid billing
1-800-343-9000

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

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

http://www.cms.hhs.gov/LowIncSubMedicarePresCov/03_MedicareLimitedIncomeNET.asp
http://humana.com/pharmacists/resources/li_net.asp

Point of Sale (POS) Facilitated Enrollment:

See Limited Income Newly Eligible Transition Program (LINET).

Prescription Appeals Process:

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

The process for appealing is the same whether you 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.

Prescription Co-Payment Levels:

2016	Generic	Brand
Level 1	\$2.95	\$7.40
Level 2	\$1.20	\$3.60
Level 3	\$0	
Level 4	15% of drug or co-pay, whichever is less.	

2017	Generic	Brand
Level 1	\$3.30	\$8.25
Level 2	\$1.20	\$3.70
Level 3	\$0	
Level 4	15% of drug or co-pay, whichever is less.	

Standard Benefits:

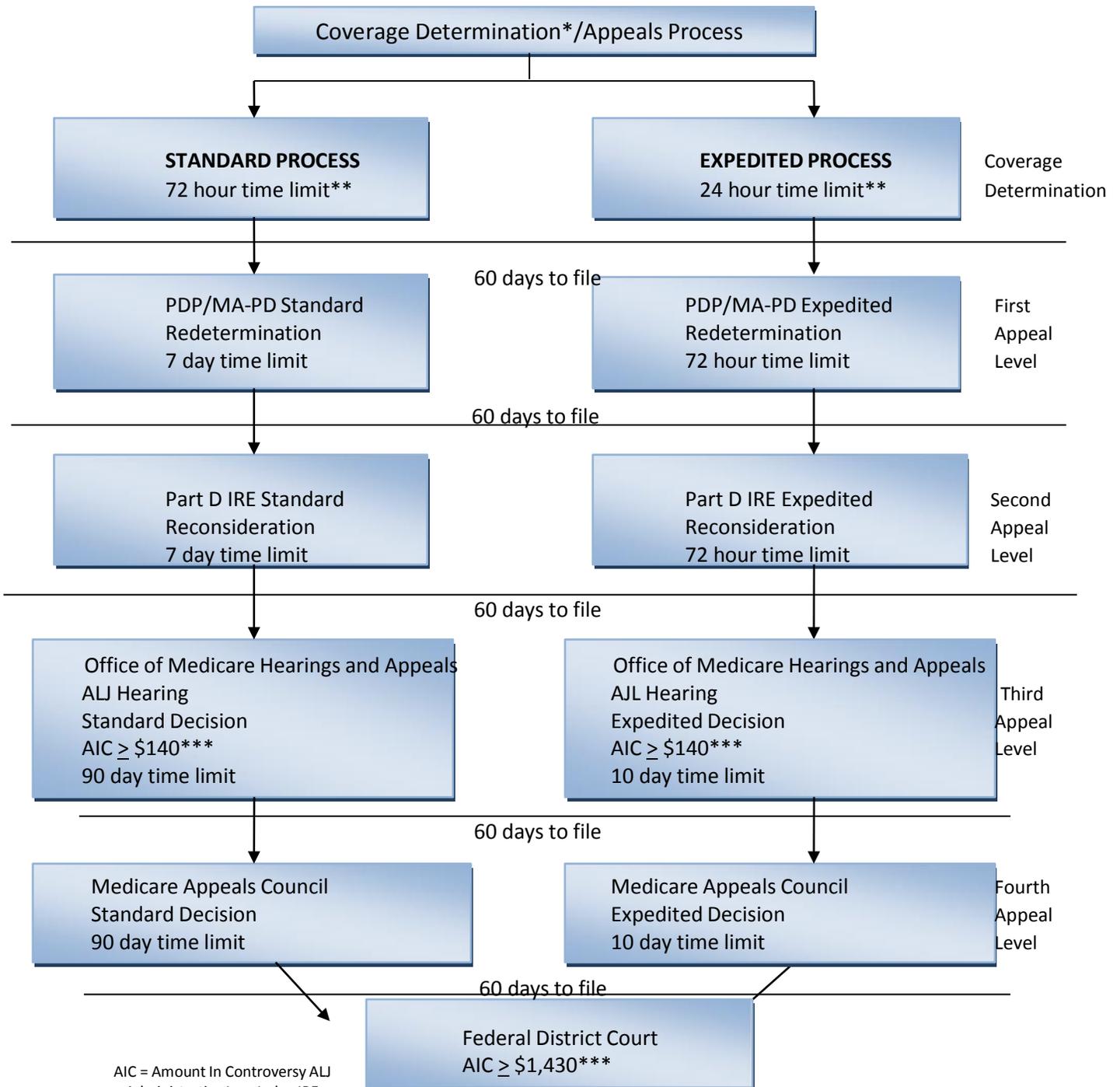
Benefit Parameters	2016	2017
Deductible	\$ 360.00	\$ 400.00
Initial Coverage Limit	\$3,310.00	\$3,700.00
Out-Of-Pocket Threshold	\$4,850.00	\$4,950.00
Total Covered Drug Spend at OOP Threshold	\$7,515.22	\$8,071.16
Minimum Cost-Sharing in catastrophic Coverage	\$2.95/\$7.40	\$3.30/\$8.25
LIS Copayments		
Institutionalized	\$0	\$0
Up to or at 100% FPL	\$1.20/\$3.60	\$1.20/\$3.70
Other LIS	\$2.95/\$7.40	\$3.30/\$8.25
Partial LIS Deductible/Cost-Sharing	\$74.00/15%	\$82.00/15%

Transition Policy – 30 Day Supply:

Also known as a “temporary first-fill”, allows new (Part D) to get temporary coverage of drugs they were taking when they joined if those medications are not covered by their new plan.

The amount paid for the transition amount would depend on the plan and the cost the plan would have charged under a coverage exception.

Medicare Prescription Drug
(Part D)



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

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

*A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, by the enrollee's appointed representative or by the enrollee's physician or other prescriber.

**The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.

***The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2014.

MEDICARE

Basic Information and Coverage



Accountable Care Organizations (ACOs):

An ACO is a group of doctors, hospitals, and other health care providers who work together to provide better, more coordinated care. Doctors and hospitals in an ACO communicate with the patient and each other to provide coordinated care.

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

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html>

Ambulance Coverage:

If it is an emergency, Medicare will generally cover ambulance services. They will cover a beneficiary if the ambulance is the only safe way to transport (medically necessary) and if the person is transported to and from certain locations.

Medically necessary (or emergency) is when your health is in serious danger and every second counts to prevent the health from getting worse.

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

Non-Emergency: Medicare coverage of a non-emergency situation is very limited. If the trip is scheduled as a way to transport you from one location to another when health is not in immediate danger, it will not be considered an emergency.

Medicare will cover non-emergency services if the person is confined to a bed or need vital medical services during the trip and is only available in an ambulance.

Medicare will never pay for ambulance services.

<http://www.medicare.gov/Publications/Pubs/pdf/11021.pdf> CMS Publication No. 11021, Revised January 2012

Balance Billing

- In New York State, limits apply to the amount a physician may charge a Medicare beneficiary to 105% of the amount approved by Medicare.
- Beneficiary is still required to pay the Medicare deductible and co-payment on each bill thereafter.
- Law applies to more specialized services and treatments provided in a doctor's office or clinic. Also applies to all physician treatments and services provided on an inpatient basis in the hospital.

- Does not apply to participating doctors who accept Medicare assignment in all cases.
- Law excludes CPT codes 99201-99215 and 99341-99353, which include the more basic Medicaid examinations, and routing office or home visits. For these services, the Federal limit of 115% of the Medicare approved amount applies.
- If discrepancies are noted, beneficiaries may request their Medicare insurance carrier to review the EOMB. Review must be requested within 6 months of the date of the EOMB. If dissatisfied with the results of the review, beneficiary may seek a higher level of review as directed by their Medicare insurance carrier.
- In New York State, QMB eligible enrollees are responsible for Medicaid Co-Payments.



Coordination of Benefits and Recovery Center (BCRC):

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

Medicare subcontracts the coordination of primary, secondary and third party payers. This subcontractor can review and update a person's billing information. Supporting documentation may need to be supplied in certain circumstances. COB also can assist with problems with Medicare coverage status, auto no-fault, workman's compensation, liability, or change in insurance coverage or employment status.

Durable Medical Equipment (DME):

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

Diabetic Supplies - In July 2013, Medicare implemented a National Mail-Order Program for diabetic testing supplies. If a person does not wish to use mail-order, they can still obtain diabetic supplies at a local store. The store cannot charge more than any unmet deductible and 20% coinsurance if they accept assignment (which means they accept the Medicare-approved amount as payment in full). If the store does not accept assignment, they may charge more than 20% coinsurance and any unmet deductible.

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

To find a Medicare approved supplier in your area, go to www.dmecompetitivebid.com or www.medicare.gov/Supplierdirectory

CMS Publication No. 11461: <http://www.medicare.gov/Pubs/pdf/11461.pdf>

Foreign Travel:

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

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

Medigap plans cover 80 percent of the cost of medically necessary emergency care services beginning the first 60 days of each trip outside the USA with a \$250 deductible and up to \$50,000 in a lifetime.

Foreign Living

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

Home Health Aide:

Medicare covers home health aide services if:

- 1) Person qualifies for Medicare Home Health Care
- 2) Needs Skilled Care
- 3) Or if person is terminally ill and qualifies for Medicare's Hospice benefit.

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

Home Health Care:

Home care is only approvable by Medicare when a beneficiary meets certain criteria such as: a person is considered homebound and in need of physical, speech or occupational therapy services, or in need of skilled nursing on an intermittent or part-time or short-term basis. Homecare must be certified by a doctor. The Medicare Home Health Care benefit will not pay for 24/7 care, nor will it pay for an indefinite period of time.

Home care is usually initiated when the family contacts a Medicare participating home health care agency (HHA). The agency will 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.

- You can find a Medicare-approved home health agency at <http://www.medicare.gov/homehealthcompare/>
- A CMS published booklet on Medicare and Home Health Care can be found at: <http://www.medicare.gov/Publications/Pubs/pdf/10969.pdf> CMS Publication No. 10629, Revised May 2010

Hospice:

Hospice is a special way of caring for people who are terminally ill. You can get Medicare hospice benefits when you meet all the following conditions:

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

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

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

- <http://www.medicare.gov/Publications/Pubs/pdf/02154.pdf> CMS Publication No. 12154, Revised August 2013.

Non-Covered Medicare Services:

- **Alternative medicine**, including experimental procedures and treatments, acupuncture, and chiropractic services (other than manual subluxation of the spine);
- **Most care received outside of the United States;**
- **Cosmetic surgery** (unless it is needed to improve the function of a malformed part of the body);
- **Most dental care;**
- **hearing aids** or the examinations for prescribing or fitting hearing aids (except for implants to treat severe hearing loss in some cases);
- **Personal care or custodial care**, such as help with bathing, toileting and dressing (unless homebound and receiving skilled care) and nursing home care (except in a SNF, if eligible);

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

Filing Direct Medical Payment Claims to Medicare – 1490s

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

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

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

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

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



Reverse Mortgages

Will I lose my government assistance if I get a reverse mortgage?

A reverse mortgage does not affect regular Social Security or Medicare benefits. However, if you are on Medicaid or Supplemental Security Income (SSI), any reverse mortgage proceeds that you receive must be used immediately. Funds that you retain count as an asset and could impact eligibility. For example, if you receive \$4,000 in a lump sum for home repairs and spend it all the same calendar month, everything is fine. Any residual funds remaining in your bank account the following month would count as an asset. If the total liquid resources (including other bank funds and savings bonds) exceed \$2,000 for an individual or \$3,000 for a couple, you would be ineligible for Medicaid. To be safe, you should contact the local [Area Agency on Aging](#) or a Medicaid expert.

For more information, visit <http://www.reversemortgage.org/>

NOTES:

COMPLAINTS

Where to Report What!

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

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

Heather Leddick at Heather.Leddick@aging.ny.gov

Or On-Line At:

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

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

Compliance issues with Medicare Advantage and PDPs:

SafeGuardServicesWebMg@hpe.com

Medicare Marketing:

Surveillance@cms.hhs.gov

Carbon copies to Rachel.Walker@cms.hhs.gov and State HIICAP Office

Medicare Part A and Part B Issues:

RONYBeneficiary@cms.hhs.gov

Medicare Part D Issues:

PartDComplaints_RO2@cms.hhs.gov

Medigap-Supplemental Issues:

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

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

Original Medicare and/or Medicare Summary Notice Billing Concerns: The Senior Medicare Patrol Project (SMP) is to establish a coordinated state-federal approach to prevent fraud and abuse in the Medicare/Medicaid programs. The United States General Accounting Office estimates that \$1 out of every \$7 spent on Medicare is paid inappropriately due to error, fraud, or abuse.

LiveOn NY, 1-877-678-4697

Prescription Concerns with Medicare Advantage Plans and PDPs:

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

Provider Errors:

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

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

- E-mail: bmfa@omig.ny.gov
- Toll-free: 877-873-7283
- Telephone: 518-402-1378
- Fax: 518-408-0480
- Internet: www.omig.ny.gov
- Mail: NYS OMIG – Bureau of Medicaid Fraud Allegations
800 North Pearl Street
Albany, NY 12204

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

MEDICARE ENROLLMENT PERIODS

5 Star Special Enrollment Period: December 8th until November 30th

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

Annual Election Period (AEP): October 15th to December 7th

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

Annual Disenrollment Period (ADP): January 1st to February 14th

- One opportunity to switch back to Original Medicare, with or without a prescription drug plan (PDP).
- With this one-time switch, a person is allowed to purchase a stand-alone Part D prescription plan (PDP), regardless of whether they had drug coverage previously.
- You will not be able to switch between Medicare Advantage plans.
- You will not be able to join a Medicare Advantage Plan during this time.

General Enrollment Period (GEP): January 1st to March 31st

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

Initial Enrollment Period (IEP):

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

Special Enrollment Periods:

Please see the following pages produced by the Medicare Rights Center to view the special enrollment periods available. This chart can be found at: http://www.medicareinteractive.org/uploadedDocuments/mi_extra/SEP-Chart.pdf

NOTES:

Last Updated: March 2015

Special Enrollment Periods for Medicare Advantage Plans and Medicare Part D Drug Plans¹

You're limited in when and how often you can join, change or leave a Medicare Advantage plan (also known as a Medicare private health plan) or drug plan (Part D).

- You can enroll in a Medicare Advantage (MA) or Part D plan during the initial period when you first qualify for Medicare.²
- During the first 45 days of each year (the Medicare Advantage Disenrollment Period, or MADP, January 1 through February 14), you can leave your Medicare Advantage plan and change to Original Medicare with or without also selecting a separate stand-alone Medicare drug plan. You can't make any changes to your coverage during this period if you have Original Medicare. You can't switch from one Medicare Advantage plan to another during this period.
- During Fall Open Enrollment, October 15 through December 7, you can change how you get your Medicare health coverage and enroll in, change or drop Medicare drug coverage.
- Outside of the above three periods, you can only change how you get your health coverage and enroll in, change or drop Part D drug coverage if you qualify for a Special Enrollment Period (SEP).

Special Enrollment Periods

The length of the Special Enrollment Period (SEP) and the effective date of your new coverage vary depending on the reason for the SEP. The plan and, in some cases, the Centers for Medicare & Medicaid Services (CMS), determine whether you qualify for an SEP.

The SEPs in the tables below let you change your Medicare Advantage plan, Medicare drug plan or both. The rules for changing Medicare drug plans are the same whether you are in a stand-alone drug plan that only covers drugs or a Medicare Advantage plan that covers both health care and drugs.

Retroactive Disenrollment

In some cases, CMS may let you retroactively disenroll from your Medicare private health or drug plan. CMS decides the date the disenrollment starts. For example, if you thought you were enrolling in a stand-alone drug plan but instead were misled into joining a Medicare Advantage health plan that includes drug coverage, you can request for your plan disenrollment to go back to the date you first joined the Medicare Advantage plan.

If you're granted retroactive disenrollment, it would be as if you never enrolled in the Medicare Advantage plan. The plan will likely take back any payments it made for your health care and drugs. In this case, you'll want to make sure you have health and drug coverage for the period for which you were retroactively disenrolled. You may have another type of insurance that will pay bills from the retroactive period. Or you may request retroactive reinstatement into the Medicare coverage you had before enrolling in the plan you didn't want. Bills for care and drugs you got while in the plan you didn't want would have to be resubmitted to that other plan.

¹ The information in this chart comes from the "[Medicare Prescription Drug Manual: Eligibility, Enrollment and Disenrollment, Section 30](#)" and the "[Medicare Managed Care Manual: Medicare Advantage Enrollment and Disenrollment, Section 30](#)."

² Eligibility requirements and initial enrollment periods for Medicare Advantage and Part D are different. You're eligible to enroll in a Medicare drug plan if you have Part A, Part B or both and live in the service area of a Medicare drug plan. The Part D Initial Enrollment Period is usually the same as the Initial Enrollment Period for Part B, which is the seven-month period that begins three months before you qualify for Part B and ends three months after the month you qualify. You're eligible to enroll in a Medicare Advantage plan if you have **both** Parts A and B. You usually can't get a Medicare Advantage plan if you have End-Stage Renal Disease. The Initial Coverage Election Period (ICEP) for Medicare Advantage begins three months before you are enrolled in both Parts A and B and ends either the last day of the month before you enrolled in both Parts A and B or the last day of your Part B initial enrollment period, whichever is later.

If you got a lot of health care and drugs while in the plan you didn't want, think carefully about whether it's a good idea to request retroactive disenrollment. You can also request prospective disenrollment, which will change your coverage going forward. In this case the plan won't recoup payments it's already made.

If you want to switch from one plan to another, it's usually better to just enroll in the plan you want to enroll in. You'll be automatically disenrolled from your old plan. It's best to call 800-MEDICARE to enroll in a new plan rather than calling the plan directly.

Premium Penalty for Late Enrollment into Part D

If you do **not** enroll in Part D when you're first eligible, and you don't have other drug coverage that is at least as good as Medicare's (creditable coverage) for 63 days or more, you'll likely have to pay a premium penalty if you later enroll in a Part D plan.

While SEPs let you enroll in Part D outside of a standard enrollment period, you will still owe a premium penalty for late Part D enrollment in many cases. There are two exceptions: You won't have a penalty if you qualify for Extra Help—a federal program that helps pay for most of the costs of the Medicare drug benefit— or if you show that you got inadequate information about the creditability of your other drug coverage.

Table of Contents

The table in the following pages explains when a Special Enrollment Period may apply to you, how long each SEP lasts, and when your new coverage will begin. If you qualify for different SEPs at the same time, pick the one that is most convenient for your circumstances.

1. You have creditable drug coverage or lose creditable coverage through no fault of your own
2. You choose to change employer/union coverage (through either current or past employment)
3. You're institutionalized
4. You're enrolled in a State Pharmaceutical Assistance Program (SPAP)
5. You have Extra Help, Medicaid or a Medicare Savings Program
6. You want to disenroll from your first Medicare Advantage plan (MA plan)
7. You enroll in/disenroll from PACE (Program of All-Inclusive Care for the Elderly)
8. You move (permanently change your home address)
9. You've had Medicare eligibility issues
10. You're eligible for a Special Needs Plan (SNP) or lose eligibility for your SNP
11. You experience contract violations or enrollment errors
12. Your plan no longer offers coverage
13. You disenroll from your Medicare Advantage plan during the Medicare Advantage Disenrollment Period
14. You qualify for a new Part D initial enrollment period when you turn 65
15. You want to enroll in a five-star Medicare Advantage plan or Part D plan
16. You have been in a consistently low-performing Medicare Advantage or Part D plan
17. Your Medicare Advantage plan terminates a significant amount of its network providers
18. You experience an "exceptional circumstance"

Special Enrollment Periods

You have an SEP if...	Your SEP lasts...	Your coverage begins...
1. You lose creditable drug coverage through no fault of your own or want to keep or enroll in creditable coverage.		
You, through no fault of your own , lose drug coverage that is at least as good as or better than Medicare's (creditable) or your drug coverage is reduced so that it is no longer creditable. (This does not include losing your drug coverage because you do not pay, or cannot afford, your premiums.)	Your SEP to join a Medicare private plan with drug coverage or a stand-alone Medicare drug plan begins the month you are told your coverage will end and lasts for <ul style="list-style-type: none"> 2 months after you lose your coverage; or 2 months after you receive notice, whichever is later. 	The first day of the month after you submit a completed application; or Up to 2 months after your SEP ends, if you request it.
You want to disenroll from Medicare drug coverage to maintain or enroll in another type of creditable drug coverage such as VA, TRICARE or a state pharmaceutical assistance program (SPAP) that offers creditable coverage.	You can use this SEP to disenroll from a Medicare private plan with drug coverage or a stand-alone Medicare drug plan whenever you are able to enroll in another type of creditable coverage.	The first day of the month after your plan receives your disenrollment request.
2. You join or drop employer/union health and/or drug coverage regardless of whether it is creditable. Employer coverage may be current or former (retiree plan).		
You have an SEP if...	Your SEP lasts...	Your coverage begins...
You choose to: <ul style="list-style-type: none"> enroll in or disenroll from a employer/union-sponsored Medicare private health or drug plan disenroll from a Medicare private health or drug plan to take employer/union-sponsored coverage. disenroll from employer/union-sponsored coverage of any kind (including COBRA³) to enroll in a Medicare private health or drug plan. 	Your SEP to join or disenroll from a Medicare private health or drug plan, or to switch private health or drug plans is available to persons who have or are enrolling in an employer plan and ends two months after the month in which your employer or union coverage ends.	Up to three months after the month in which you submit a completed enrollment application. If your employer/union was late sending in the application, your coverage may begin retroactive to when you submitted the application.

³ If you are disenrolling from COBRA and signing up for a Medicare private health plan you must already have enrolled in Parts A and B. You can only delay enrollment into Part B without penalty if you have health insurance from a current employer. COBRA is not considered current employer insurance. You do not need to have Medicare Part B to enroll in a Part D plan.

You have an SEP if...	Your SEP lasts...	Your coverage begins...
3. You're institutionalized.		
<p>You move into, reside in, or move out of a qualified institutional facility: a skilled nursing facility, nursing home, psychiatric hospital or unit, Intermediate Care Facility for the Mentally Retarded—ICF/MR, rehabilitation hospital or unit, long-term care hospital, or swing-bed hospital⁴ or;</p> <p>You qualify to enroll in a Special Needs Plan (SNP) for institutionalized people⁵</p>	<p>Once you move to or reside in a qualified institution, you can enroll in or disenroll from a Medicare private health or drug plan or change your plan once a month. (If you are in an Medicare private health plan, you may change to another Medicare private health plan or change to Original Medicare)</p> <p>In addition, after you move out of the facility, you have two months to enroll in or disenroll from a Medicare private health plan or drug plan, or to switch to another plan (including Original Medicare if you are in a MA plan).</p> <p>You can enroll in or disenroll from the SNP for institutionalized people at any time.</p>	<p>The first day of the month after you submit a completed application, but not before you become institutionalized or qualify to enroll in a Special Needs Plan for institutionalized people.</p>
You have an SEP if...	Your SEP lasts...	Your coverage begins...
4. You're enrolled in a qualified⁶ State Pharmaceutical Assistance Program (SPAP) or lose SPAP eligibility.		
<p>You're enrolled in a qualified SPAP (no matter how long you have been a member).</p>	<p>You have an SEP to choose once per year, at any time during the year, to join a Medicare private health or drug plan for the first time or to change to another private health or drug plan, including joining one that works with your SPAP. (If you are automatically enrolled in a Part D plan by your SPAP, you will not have this SEP.)</p> <p>You may not drop Part D coverage using this SEP.</p>	<p>The first day of the month after you submit a completed application.</p>

⁴ Only residents of a skilled nursing facility, nursing home, psychiatric hospital or ICF/MR will be eligible to pay a \$0 copay for prescription drugs with Extra Help in 2010 and 2011.

⁵ You qualify for an institutional SNP if you: (1) Have lived, for at least 90 days, in a long-term care facility that is served by the SNP or (2) have met your state's guidelines for requiring an institutional level of care for at least 90 days, whether you live in an institution or in a community setting (for example, at home or in a group residence). You can still qualify for an institutional SNP before you have received care for at least 90 days if it is likely that you will need long-term care for at least 90 days.

⁶ This list of qualified SPAPs can be found at <http://www.cms.gov/States/Downloads/QualifiedSPAP2.17.09.pdf>

You lose SPAP eligibility	You have an SEP to join or switch to another Medicare drug plan or Medicare health plan with drug coverage. This applies even if you didn't have Part D before. The SEP starts the month you lose the SPAP because you're no longer eligible or are notified of the loss (whichever comes first) and continuing for two months after you're notified of the loss or lose the SPAP (whichever comes later).	The first day of the month after you submit a completed application.
You have an SEP if...	Your SEP lasts...	Your coverage begins...
5. You have Medicaid, a Medicare Savings Program and/or Extra Help. (You will have no Part D premium penalty if you have Extra Help.)		
You have Medicaid, a Medicare Savings Program or Supplemental Security Insurance. (You get Extra Help automatically.)	You will get an SEP to join, disenroll from ⁷ or switch Medicare private health or drug plans beginning the month you become eligible for Medicaid or the MSP. <i>-Continued on Next Page-</i> As long as you have Medicaid or an MSP, you can switch health or drug plans once a month.	The first day of the month after you submit a completed application to the Medicare private health or Part D plan. <ul style="list-style-type: none"> • If you do not select a Part D plan yourself, CMS will auto-enroll you in a PDP plan effective the first day of the second month after CMS identifies your Extra Help status. CMS will enroll you in the Limited Income NET program through Humana from the month you qualified for Extra Help until the month your auto-enrolled plan starts. • If you recently qualified for Extra Help and choose your own Medicare drug plan instead of waiting to be auto-enrolled in one by CMS, you may receive coverage of any uncovered months through the Limited Income NET program through Humana. • If you enroll in a Medicare

⁷ **Don't drop Part D coverage if you have Medicaid! In most cases you will lose your Medicaid benefits.** For more information, call your local Medicaid office.

		private health plan without drug coverage, Medicare will automatically enroll you in a Medicare private health plan with drug coverage (MA-PD) offered by that same company. Your MA-PD enrollment could be retroactive.
You have Extra Help because you applied for it. (You do not have Medicaid or a Medicare Savings Program.)	You will get an SEP to join, disenroll from or switch Medicare private drug plans beginning the month you become eligible for Extra Help. This includes stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug plans (MA-PDs). As long as you have Extra Help, you can switch drug plans once a month.	The first day of the month after you submit a completed application to the Part D plan. <ul style="list-style-type: none"> • If you do not select a Part D plan yourself, CMS will auto-enroll you in a PDP plan effective the first day of the second month after CMS identifies your Extra Help status. CMS will enroll you in the Limited Income NET program through Humana from the month you qualified for Extra Help until the month your auto-enrolled plan starts. • If you recently qualified for Extra Help and choose your own Medicare drug plan instead of waiting to be auto-enrolled in one by CMS, you may receive coverage of any uncovered months through the Limited Income NET program through Humana.
If you lose Medicaid or MSP benefits⁸.	You have one SEP to switch your Medicare private health or drug plan that begins the month you're notified that you will lose Medicaid or MSP benefits and continues for two months after.	The first day of the month after you submit a completed application.
You will lose Extra Help for	You have a one-time SEP to	The first day of the month after

⁸ If you lose your Medicaid or MSP benefits your Extra Help will continue. If you are deemed eligible for Extra Help by either having Medicaid, SSI or an MSP between January 1 and June 30, then you are eligible for Extra Help for the remainder of the calendar year. If you are deemed eligible for Extra Help between July 1 and December 31 you will be eligible for Extra Help for the remainder of that calendar year and the following calendar year.

the next calendar year because you are no longer deemed eligible for it. (You are deemed eligible if you are enrolled in Medicaid, an MSP or SSI.)	disenroll from or switch your Medicare private health or drug plan from January–March if you were notified you lost Extra Help before January 1.	you submit a completed application.
You lose Extra Help during the calendar year (occurs in limited circumstances)	You have a one-time SEP to disenroll from or switch your Medicare private drug plan for two months after you are notified of losing Extra Help.	The first day of the month after you submit a completed application
You have an SEP if... Your SEP lasts... Your coverage begins...		
6. You want to disenroll from your FIRST Medicare private health plan (Medicare Advantage – MA)		
You select a Medicare private health plan when you first qualify for Medicare Part B based on age (65 years old) ⁹	You can disenroll from your Medicare private health plan at any time during the 12-months after your health plan coverage first started and go back to Original Medicare with or without joining a stand-alone Medicare drug plan (PDP).	Depends upon the situation.
You dropped your Medigap policy to enroll in a Medicare private health plan for the first time and want to re-enroll in a Medigap policy during your “trial period.” ¹⁰ The trial period lasts for 12 months after you enroll in a Medicare private health plan for the first time.	You can disenroll from your Medicare private health plan at any time during the trial period – the 12-months after your MA coverage first started-- and go back to Original Medicare with or without joining a stand-alone Medicare drug plan (PDP).	Depends upon the situation.
You have an SEP if... Your SEP lasts... Your coverage begins...		
7. You enroll in/disenroll from PACE (Program of All-Inclusive Care for Elderly)		
You disenroll from a Medicare private health or drug plan to enroll in PACE.	You can disenroll from your Medicare private health or drug plan at any time to enroll in PACE.	Depends upon the situation
You disenroll from PACE to join a Medicare private health or drug plan.	Your SEP to join another Medicare private health or drug plan lasts up to two months after the effective date of your disenrollment from the PACE program.	

⁹ In this instance, under federal law if you are 65 and over, you will have guaranteed issue rights to buy certain Medigap policies. Laws in your state may offer additional protections.

¹⁰ In this instance, under federal law if you are 65 and over, you will have guaranteed issue rights to buy certain Medigap policies. Laws in your state may offer additional protections.

You have an SEP if...	Your SEP lasts...	Your coverage begins...
8. You move (permanently change your home address)		
<p>You move, permanently. You will have an SEP if you move out of your Medicare private health or drug plan's service area or if you move to an area covered by your plan but more plans are available to you in your new coverage area.</p>	<p>If you notify your Medicare private health or drug plan of a permanent move in advance, you have an SEP to switch to another private health or drug plan beginning as early as the month before your move and lasting up to two months after the move.</p> <p>If you notify your private health or drug plan of a permanent move after you move, you have an SEP to switch to another private health or drug plan, beginning the month you tell your plan, plus two more full months thereafter.</p> <p>If you did not notify your private health or drug plan about a move:</p> <ul style="list-style-type: none"> • and your Medicare drug plan learns from CMS or the post office that you moved over twelve months ago, the plan should disenroll you twelve months after your move. Your SEP to switch to another Medicare drug plan begins at the beginning of the twelfth month and continues through the end of the fourteenth month after your move. • and your Medicare private health plan learns from CMS or the post office that you moved over six months ago, the plan should disenroll you twelve months after your move. Your SEP to switch to another Medicare private plan 	<p>You may choose to begin coverage any time between the first day of the month you moved (as long as you have submitted a completed application), and up to three months after your Medicare private health plan or drug plan receives the completed enrollment application.</p>

	begins at the beginning of the sixth month and continues through the end of the eighth month after your move.	
You become eligible for Part D or Medicare Advantage because you have: <ul style="list-style-type: none"> Moved back to the U.S. after living abroad You were released from prison (You aren't eligible for Part D or Medicare Advantage if you live outside the U.S. or are in prison.)	You qualify for an SEP to enroll in Part D plan or a Medicare Advantage plan. You have an SEP to join a private health or drug plan beginning as early as the month before your move and lasting up to two months after the move.	You may choose to begin coverage any time between the first day of the month you moved (as long as you have submitted a completed application), and up to three months after your Medicare private health or drug plan receives the completed enrollment application.
You have an SEP if... Your SEP lasts... Your coverage begins...		
9. You have had Medicare eligibility issues.		
You have received retroactive enrollment into Medicare	Your enrollment period to join a Medicare private health or drug plan for the first time begins the month that you receive notice of your Medicare entitlement and continues for an additional two months after the month the notice is received. ¹¹	Depends on the situation.
You do not have premium-free Part A and you enroll in Part B during the General Enrollment Period (Jan-Mar) with your Part B coverage beginning July 1.	You have an SEP to join a Medicare stand-alone drug plan from April 1-June 30 (after you have enrolled in Part B).	July 1 of that year.
You lost Part B but still have Part A and are involuntarily disenrolled from your MA plan	You have an SEP to enroll in a Medicare stand-alone drug plan that begins when you learn you lost Part B and continues for two additional months.	The month following the month you applied.
You have an SEP if... Your SEP lasts... Your coverage begins...		
10. You're eligible to join a Special Needs Plan (SNP) or you lose SNP eligibility.		
You're eligible to enroll in a Medicare SNP.	You can leave your Medicare private health or drug plan at any time to enroll in a SNP if you are eligible. If you have a chronic condition	The first day of the month after you submit a completed application.

¹¹ This enrollment period serves as your initial enrollment period for Medicare drug coverage, so you will not face a premium penalty as long as you enroll in a plan within the time limits of your SEP.

	and want to join a chronic care SNP for which you are eligible, you can do so at any time. The SEP ends when you join the private health or drug plan. Note: If you have another chronic condition, you get another SEP to join a different SNP that covers this other condition.	
You lose eligibility to continue getting coverage through your SNP. (SNPs must continue to cover you for at least one month if you become ineligible and for up to six months if it's likely that you will re-qualify within six months.)	You can join another Medicare private health or drug plan beginning the month you no longer qualify for the SNP and ending either three months after your continued period of enrollment ends or when you enroll in another plan, whichever comes first.	The first day of the month after you submit a completed application.
You're enrolled in a chronic care SNP, but your provider fails to confirm that you have the chronic condition required for eligibility by the end of the first month of enrollment.	You have an SEP to enroll in a Medicare private health plan with drug coverage or a Medicare private health plan without drug coverage and a stand-alone Medicare drug plan. The SEP begins the month the SNP plan notifies you that you don't qualify and ends two full months after the month of notification or when you enroll in another Medicare private health or drug plan, whichever is earlier.	The first day of the month after you submit a completed application.
You have an SEP if...	Your SEP lasts...	Your coverage begins...
11. You experience contract violations (such as misleading marketing) or enrollment errors.		
Your Medicare private health or drug plan violated a material provision of your contract such as: <ul style="list-style-type: none"> • Failing to provide you on a timely basis with benefits available under the plan; • Failing to provide benefits in accordance with applicable quality standards; • Giving misleading information in the private health or drug plan's marketing to get you to enroll in the plan. 	Your SEP to switch to another Medicare private health or drug plan begins once the regional CMS office has determined that a violation has occurred. (If you are in an MA plan, your SEP allows you to disenroll from your plan and either change to Original Medicare or join another MA plan) <p>You can switch to another Medicare private health or drug plan during the last month of enrollment in your current plan. If you do not choose another private health or drug plan</p>	The effective date of the new Medicare private health or drug plan will be the first of the month following the month the new private health or drug plan receives the completed application or up to three months after it receives the completed application. <p>In some cases, CMS may process a retroactive disenrollment and/or retroactive enrollment in another private health or drug plan</p>

	immediately, your SEP is extended for 90 days from the time of your disenrollment in the plan.	
A federal employee made a mistake in your enrollment or disenrollment in a Medicare drug plan	You have one SEP to enroll in and/or disenroll from a Medicare drug plan that begins the month of CMS approval and lasts two additional months.	Depends on the situation.
CMS sanctions (finds fault with) a Medicare private health or drug plan and you disenroll in connection with that sanction.	The length and start date of your SEP to join a new private health or drug plan depends on the situation.	Depends on the situation.
CMS determines that your previous drug coverage did not adequately inform you of a loss of creditable coverage or that your drug coverage was not creditable.	You have one SEP to enroll in or disenroll from a Medicare drug plan that begins the month of CMS approval and lasts two additional months. (In this case, CMS may waive your premium penalties.)	Depends on the situation.
You have an SEP if... Your SEP lasts... Your coverage begins...		
12. Your Medicare private health or drug plan no longer offers Medicare coverage.		
Your Medicare private health plan or drug plan doesn't renew its service. (Your private health plan or drug plan must notify you by October 1 if it won't offer Medicare drug or health coverage next year, and it must continue to provide coverage through the end of the current calendar year.)	Your SEP to switch to another Medicare private health or drug plan lasts from December 8 of that year through the last day of February of the next year. (This SEP is in addition to the Fall Open Enrollment period from October 15 through December 7, when you can switch Medicare health coverage and enroll or disenroll from Part D drug coverage.)	<ul style="list-style-type: none"> • Enrollments made from October 15 through December 31 are effective January 1. • Enrollments made during January are effective February 1. • Enrollments made in February are effective March 1.
Mid-year, your Medicare private health plan or drug plan closes or changes its contract with CMS so that you will be forced to disenroll from the private health or drug plan. (Your private health or drug plan must notify you 60 days before the proposed date of termination or modification.)	Your SEP to switch to another Medicare private health or drug plan begins two months before the proposed closing or changes take place and ends one month after they occur.	You can ask that your new private health or drug plan coverage start the month after you get notice and up to two months after your old Medicare private health or drug plan coverage ends.
CMS terminates your Medicare private health or drug plan's contract because of misconduct or other problems. (Your private health or drug plan must give you 30 days notice before the termination date.)	Your SEP to switch to another Medicare private health or drug plan begins one month before the termination occurs and lasts for two months afterward.	You can choose to have your new Medicare private health or drug plan coverage begin up to three months after the month your old coverage ended.
CMS decides to immediately	CMS will notify you of the	Depends on the situation.

terminate its contract with your Medicare private health or drug plan.	termination and your SEP. The termination may be mid-month.	
You have an SEP if...	Your SEP lasts...	Your coverage begins...
13. You disenroll from your Medicare private health (MA) plan during the Medicare Advantage Disenrollment Period (MADP)		
You disenroll from your Private Health Plan (MA) plan during the Medicare Advantage Disenrollment Period (January 1 – February 14)	You should enroll in a Medicare stand-alone drug plan when you disenroll from your MAPD plan. You can disenroll from your MAPD plan by submitting a disenrollment request or by simply enrolling in a stand-alone drug plan.	The month following the month you submit an enrollment request.
You have an SEP if...	Your SEP lasts...	Your coverage begins...
14. You qualify for new Part D initial enrollment period when you turn 65		
You qualify for new Part D initial enrollment period to join a Medicare drug plan because you are a person with a disability who is turning 65 (If you are already enrolled in a Medicare drug plan and are paying a late premium penalty, the penalty will end when the enrollment period starts)	You have an SEP to disenroll from a Medicare private health (that does or does not include drug coverage) to join Original Medicare or to enroll in a Medicare private health plan that does not include drug coverage. You may also use your additional IEP to join a stand-alone drug plan. The SEP begins and ends with the additional Part D IEP to join a Medicare drug plan—usually the seven month period including three months before you turn 65, the month you turn 65, and the three months after you turn 65.	If you are not already enrolled in a Part D plan, your coverage will usually start the month following the month you submit an enrollment request.
You have an SEP if...	Your SEP lasts...	Your coverage begins...
15. You want to enroll in a five-star Medicare Advantage plan or Part D plan		
You want to enroll in an MA or Part D plan that has an overall Plan Performance Rating of five stars and you're otherwise eligible to enroll in the plan. (For example, you live in the plan's service area.)	Plan Performance Ratings are released every fall and apply to the following calendar year. Your SEP to join a five-star MA or Part D plan starts December 8 of the year before the plan is considered a five-star plan. It lasts through November 30 of the year the plan is considered a five-star plan. You can use this SEP to change plans one time per year.	<ul style="list-style-type: none"> • Enrollments December 8 through December 31 are effective January 1. • Enrollments January 1 through November 30 are effective the month following the month you submit an enrollment request.

You have an SEP if...	Your SEP lasts...	Your coverage begins...
16. You have been in a consistently low-performing Medicare Advantage or Part D plan		
<p>You have been in a consistently low-performing plan, meaning that the plan has received an overall Medicare star rating of less than three stars for three consecutive years.</p>	<p>You have an SEP to enroll into a higher quality plan throughout the year. You should receive a notice from CMS in late October, saying that you are in a low-performing plan. You have the remainder of that year, as well as the following year, to switch to a plan rated 3 stars or more. To use this SEP, you must call 800-MEDICARE directly. Note: This is separate from the five-star SEP listed above.</p>	<p>The month following the month you submit an enrollment request.</p>
17. You experience an “exceptional circumstance”		
<p>If your circumstances do not fit into any of the other SEP categories, you have the right to ask CMS to grant you an SEP based on your particular exceptional circumstances.¹²</p>	<p>Depends on the SEP.</p>	<p>Depends upon the circumstances.</p>

¹² CMS can also grant “exceptional circumstance” SEPs to groups identified by a common problem or characteristic (for example, members of a particular plan who were all misled about the plan’s offerings). Many of the SEPs mentioned in this chart were created as “exceptional circumstance” SEPs.

NOTES:

MARKETING

Marketing Rules: Educational Events:

- No plan marketing activities at educational events!
 - Event advertising materials must include disclaimer.
 - No sales activities, or distribution/acceptance of enrollment forms and/or business reply card.
- Plans may distribute:
 - Promotional gifts (retail valued at \$15 or less).
 - Medicare and/or health educational materials.
 - Agent/broker business cards, upon beneficiary request.
 - Containing no benefit information.

Sales Events:

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

Marketing in Health Care Settings:

- No plan marketing activities in healthcare setting.
 - No sales activities or distribution/acceptance of enrollment forms.
 - Examples: waiting rooms, exam rooms, hospital patient rooms, dialysis centers, pharmacy counter areas.
- Marketing allowed
 - In common areas, such as: hospital or nursing home cafeterias, community or recreational rooms, conference rooms.
 - By providers, per current CMS Marketing Guidelines.

Sales event cancellation notice to beneficiaries:

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

Unsolicited Contacts Prohibited Activities:

- Calls to confirm receipt of mailed information.
- Approaching in common areas such as parking lots, hallways, lobbies, etc.
- Calls/visits after attendance at sales event, unless express permission given.
- Calls to former members to market plans or products.
- Plan sponsors may not e-mail prospective members at an email address obtained through friends.

- ❑ Leaving leaflets, door hangers or flyers at a prospect's home or on a car prohibited (Although leaving leaflets, door-hangers or flyers at someone's residence is prohibited, agents who have a "no show" from a prescheduled appointment may leave information the door).
- ❑ Plan sponsors may not conduct unsolicited calls to their Medigap enrollees regarding their MA or PDP products.

Unsolicited Contacts Permitted Activities:

- ❑ Calls to:
 - Existing members to conduct normal business related to plan.
 - Former members for disenrollment survey.
 - Only after disenrollment effective date.
 - No sales or marketing information.
 - Members by the agent/broker who enrolled them in the plan.
 - Beneficiaries who have given express permission.
- ❑ All plan sponsors are required to conduct outbound verification calls to new enrollees.

Where To Report When a Possible Violation is Found:

Surveillance@cms.hhs.gov

Carbon copies to Rachel.Walker@cms.hhs.gov and State HIICAP Office.

MEDIGAPS

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

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

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

Eligibility:

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

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

Open Enrollment in New York State:

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

Waiting Periods in New York State:

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

- A group health plan;
- Health insurance coverage;
- Medicare*;
- Medicaid;
- CHAMPUS AND TRICARE health care programs for the uniformed military services;
- A medical care program of the Indian Health Services or of a tribal organization;
- A state health benefits risk pool;
- A health benefit plan issued under Peace Corps Act; and
- Medicare supplement insurance, Medicare select coverage or Medicare Advantage.

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

List of Medigap Plans and Rates in New York State:

For a list of Medigap plans in New York State, please go to the following website:
<http://www.dfs.ny.gov/>

Medigap insurance will only pay if Medicare pays!

You can print a copy of the latest Medigap booklet at <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>. Or, order copies of the latest booklet through CMS' publication website. Refer to the Publications section in this guide.

Disenrolling from a Medigap plan:

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

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

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

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

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

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

Medigap Plan Benefits

For plans sold on or after June 1, 2010

	A	B	C	D	F*	G	K**	L**	M	N
Hospital Copayment Copay for days 61-90 (\$304) and days 91-150 (\$608) 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 \$1,216 in each benefit period		■	■	■	■	■	50%	75%	50%	■
Skilled Nursing Facility (SNF) Daily Copay Covers \$152 a day for days 21-100 each benefit period			■	■	■	■	50%	75%	■	■
Part B Annual Deductible Covers \$147 (Part B deductible) in 2014			■		■					
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%	■	■

* Plan F also offers a high-deductible option in which you pay a \$2,140 deductible in 2015 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 2014 out-of-pocket maximum is \$4,940 for Plan K and \$2,470 for Plan L.

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

NOTES :

PROBLEM RESOLUTION

Steps:

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

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

- 2) **Call the CMS SHIP Number - 1-888-647-6701**

With your SHIP User Unique ID, you can discuss personal information regarding a beneficiary with Medicare Representatives.

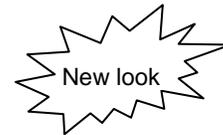
It will ask you to enter your SHIP Unique ID.



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

- 3) **Medicare Rights Center (MRC)** - NYSOFA has contracted with MRC to provide technical assistance.

- Medicare Interactive – www.medicareinteractive.org
Click on “Medicare Counselor”.
- HIICAP’s MRC HIICAP Coordinator Hotline – 1-800-480-2060.
- Technical Assistance Email – hiicap@medicarerights.org.



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

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

Brenda.LaMere@aging.ny.gov
Heather.Leddick@aging.ny.gov
Helen.Fang@aging.ny.gov

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

Date: _____

Issue Level:

(Date complaint received)

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

- MA
- PDP

SHIP CTM Pilot - MA or Part D Complaint Report

Information about Person Making this Report:

Complaint Source County: _____

Counselor: _____

Direct phone # _____ E-Mail _____

Beneficiary Information:

Name: _____

Medicare #: _____ Date of Birth: _____

Address: _____ Zip Code: _____

Phone Number#: _____

Email: _____

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

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

Date of Incident: _____

Nature of Complaint: _____

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

THERAPY LIMITS

Medicare Coverage for Outpatient Physical, Occupational and Speech Therapy

Medicare limits how much outpatient therapy it will cover, although coverage is allowed for medically necessary therapy over the cap, particularly for complex cases.

In 2016, Medicare will cover up to:

- \$1,960 worth of physical therapy (PT) and speech-language pathology (SLP) combined; and another
- \$1,960 worth of occupational therapy (OT).

After the annual Medicare Part B deductible is paid (\$166 in 2016), Medicare will pay up to 80% of the Medicare-approved amount for each service and you will be responsible for the remainder. After the limit has been reached, you will have to pay the full cost of the services (100%).

If you are approaching the limit and need more therapy, your doctor can tell Medicare that it's medically necessary for you to continue. Medicare is most likely to cover additional therapy if your case is medically complicated. If Medicare denies the claim, you can appeal through the regular Original Medicare appeals process.

The therapy limits apply to outpatient therapy received at:

- Therapists' or physicians' offices;
- Outpatient rehabilitation facilities;
- Skilled nursing facilities (SNFs) for outpatients or residents who do not have Medicare-covered stays; and
- Home, through therapists connected with home health agencies, when not part of a Medicare-covered home health benefit.

NOTES:

Elderly Pharmaceutical Insurance Coverage (EPIC) Program

Helpline: 1-800-332-3742
 Provider line: 1-800-634-1340
Albany Office: 518-452-3773
Fax: 518-452-3576
Mailing Address: EPIC
PO Box 15018
Albany, New York 12212-5018
Email: EPIC@health.state.ny.us
Website: http://www.health.ny.gov/health_care/epic/

EPIC in 2016

EPIC is New York State program that helps income-eligible seniors with their out-of-pocket Medicare Part D drug plan costs. In 2016, EPIC will continue to provide supplementary drug coverage for Part D and EPIC covered drugs after any Part D deductible is met. EPIC will also continue to cover Part D excluded drugs such as prescription vitamins and prescription cough and cold preparations.

Eligibility

To join EPIC, a senior must:

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

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

EPIC Has Two Plans Based On Income

EPIC Fee Plan:

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

Full Extra Help will have their EPIC fee waived. All fee plan members will receive Medicare Part D assistance up to \$39.73 in 2016. Non-payment of EPIC fees will result in loss of EPIC benefits.

EPIC Deductible Plan:

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

EPIC pays the Medicare Part D drug plan premiums up to \$39.73 in 2016 for members in the Deductible Plan with incomes ranging from **\$20,001 to \$23,000 if single or \$26,001 to \$29,000 if married.**

Deductible Plan members with income between **\$23,001 to \$75,000 if single or \$29,001 to \$100,000 if married** are required to pay their Medicare Part D plan premium each month. To provide Part D premium assistance, the member's EPIC deductible is reduced by the annual cost of a basic benchmark Part D drug plan (in 2016, \$477.00)

What Benefits Does EPIC Provide?

• Premium Assistance

- EPIC will pay the Medicare Part D premiums up to the benchmark amount (\$39.73 in 2016) for members with incomes up to \$23,000 if single and \$29,000 if married. If a member's income is above these amounts, then EPIC will not pay the Medicare Part D premium.
- If you are approved for the full or partial Extra Help, EPIC will provide additional premium assistance up to the benchmark amount (\$39.73 in 2016) if Extra Help does not cover the entire premium.
- If you are in a Medicare Advantage Plan, EPIC will only pay up to the benchmark amount of the drug portion. EPIC will not contribute toward the Part C premium.

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

• Drug Coverage

- EPIC provides supplemental coverage for Medicare Part D and EPIC covered drugs.
- Part D excluded drugs such as prescription vitamins and prescription cough and cold preparations will also be covered. EPIC will supplement

the member's Initial Coverage Period, Coverage Gap and the Catastrophic Coverage Period. EPIC will not supplement drugs purchased in the Medicare Part D deductible phase, if the member's plan has one.

- EPIC members should show the pharmacist their Part D and EPIC cards. Members must be sure to use a pharmacy or mail-order pharmacy that participates in both EPIC and their Part D plan, since EPIC only covers drugs purchased at participating pharmacies.
- EPIC co-payments range from \$3 to \$20 and are based on the cost of the prescription remaining after being billed to the Medicare Part D drug plan. For example, for a drug that costs \$100 at the pharmacy, the member will pay \$20. Below is the EPIC co-payment schedule:

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

EPIC Enrollees Must Also Have Medicare Part D Coverage

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

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

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

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

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

EPIC and Employer/Retiree Drug Coverage

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

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

EPIC and Extra Help

EPIC members who are income eligible for *Extra Help* to assist paying for Medicare Part D costs are required to complete an additional form titled **Request for Additional Information (RFAI)** so EPIC can apply to the Social Security Administration for Extra Help on their behalf. EPIC will provide members with a Medicare Savings Program (MSP) application and assist in completing, upon request.

The benefits of having EPIC together with Extra Help include:

- EPIC fees are waived for members with Full Extra Help.
 - Additional savings on brand name drugs (\$7.40) lowered to \$3.00
- Medicare pays Part D premiums up to \$39.73 (2016), EPIC pays up to an additional \$39.73 (2016).

EPIC will pay the De Minimus amount for all members that qualify for EPIC's premium assistance.

Enrolling in EPIC

- You can call EPIC at 1-800-332-3742 (TTY 1-800-290-9138) to request an application.
- Visit www.health.ny.gov/health_care/epic/application_contact.htm to download and print an application. You can also submit an online request for EPIC to mail you an application.

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

2016 EXTRA HELP

Enrollment:

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



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

Eligibility:

- Have Medicare and limited income (can be on Medicaid)
- Receive both Medicare and Supplemental Security Income (SSI)

LIS LEVEL	Status	2016 Resource Limit	2016 Monthly Income Limits	2016 Co-Pay	2016 Premium*
					Deductible
Full Subsidy LIS	Single	\$8,780	Has Medicaid: Up To \$ 990	\$1.20** generic \$3.60** brand	\$0
					\$0
	Married	\$13,930	Has Medicaid: Up To \$1,335	\$1.15** generic \$3.50** brand	\$0
					\$0
Single	\$8,780	No Medicaid: Up To \$1,336	\$2.95** generic \$7.40** brand	\$0	
				\$0	
Married	\$13,930	No Medicaid: Up To \$1,802	\$2.95** generic \$7.40** brand	\$0	
				\$0	
Partial (Other) LIS	Single	\$13,640	No Medicaid: Up To \$1,485	15% of drug*** or plan's co-pay, whichever is lower	Sliding Scale
					\$74
	Married	\$27,250	No Medicaid: Up To \$2,002	15% of drug*** or plan's co-pay, whichever is lower	Sliding Scale
					\$74

* \$0 Premium if person has Full Extra Help and is in a plan that offers basic coverage at or below the Extra Help Premium amount for his/her area.

** \$0 co-pay after \$4,850 in out of pocket drug costs.

*** After \$4,850 in out of pocket drug costs, you pay \$2.95/generic and \$7.40/brand-name or 5% of the drug cost, whichever is greater.

NOTES:

MEDICAID (Medicare and those with ~ Dual Eligible)

Billing:

- Doctor must always accept Medicare assignment on claims.
- Beneficiary cannot be balance billed for the 20% Medicare co-insurance and deductibles.
- Doctor may be able to refuse to accept client for future visits.
- Medicaid Billing Concerns: Computer Science Corp – 1-800-343-9000.

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

2016	Income Below	Resources Below
Single:	\$ 825 per month	\$ 14,850
Couple:	\$ 1,209 per month	\$ 21,750

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



The Medicaid Look-Back for skilled nursing facilities is now five (5) years. The new five-year look back period only applies to transfers made on or after August 8, 2006. Transfers made prior to this date will continue to have the 3 year (or 36 month look-back). This rule does not apply to Home and community Based Services (HCBS).or managed long term care (MLTC).

Part A and Part B Coordination:

- Automatic Medicaid Crossover – Medicare’s Coordination of Benefits will now automatically cross-over and submit unpaid expenses to Medicaid.
- Medicaid supplements Medicare coverage by providing services and supplies when Medicare is exhausted.
- Limited Medicaid benefits (QMB) are also available to pay for out-of-pocket Medicare cost- sharing expenses.
- Medicaid eligible beneficiaries may qualify for the SLMB and QMB assistance programs. Please refer to the Medicare Savings Program in this resource guide to learn more about these programs.

Part C – Medicare Advantage Plan Coordination:

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

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

Duals should always be screened for QMB so they should not be responsible for the Part B premium.

Note: If the dual has a spenddown, enrolling into QMB will increase their spenddown. Spenddown clients should be given the choice of whether they want the Part B premium paid directly or paying the premium and having it applied toward their spenddown.

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

Part D – Prescription Drug Coverage Coordination:

- If a dual eligible does not join a prescription drug plan, they will be automatically and randomly assigned into a benchmark drug prescription plan.
- If they choose not to participate in a prescription drug plan, they may lose all their Medicaid benefits.
- If a dual eligible has creditable drug coverage through his/her employer or union, they are no longer automatically enrolled into a Part D plan. This new policy became effective April 2009. Now duals will no longer jeopardize their current coverage.
- A dual may choose a different plan at any time if the new plan does not meet their needs.

Medicaid coverage of prescriptions for the Dual Eligible Population:

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

Claims for over-the-counter medications and prescription vitamins can be billed by the pharmacist directly to Medicaid as they are not covered under the Medicare Part D benefit. The Dual eligible enrollee should be able to obtain these products through Medicaid.

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

http://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-10-01_medicare_exempt_drugs.pdf and

http://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Procedure_Codes.pdf

Part D Drugs:

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

Compound Medications:

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

Best Available Data Policy:

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

LINET:

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

Special Enrollment Period (SEP):

- This SEP is ongoing for a dual eligible.
- There is another SEP that provides a one-time election for individuals who lose their dual eligibility.

Spend-Down:

If a person's income is above the Medicaid limit, client may qualify for Medicaid by incurring medical bills in an amount that equals the monthly spend-down.

- The spend-down must be met each month to have ongoing Medicaid.
- The spend-down must be met once to receive Extra Help for the entire calendar year. If that person meets this one-time spend-down in August or later, they will receive Extra Help for the rest of that year and the following calendar year.
- A bill only needs to be incurred to count toward the spend-down. It does not have to be paid. The date the medical service occurred is what counts, not the date of the bill.
- Medical bills, including the client and their spouse, can be considered (even if the spouse is not applying for Medicaid). However, if the spouse requested a "spousal refusal," then you may not use the spouse's bills.
- Bills for any dependent child under age 21 can be used toward Spend-down.
- Deductibles and coinsurance for Medicare, Part D or other private health insurance can be used.
- Services that are medically necessary such as chiropractors, podiatrists, drugs the Part D plan won't cover, bills of doctors who don't take Medicaid, Over the counter items.
- Paid bills (for the 3 calendar months prior to the month of application). These past due bills can also be reimbursed by Medicaid once the spend-down is met.
- EPIC – EPIC expenses and the amount EPIC pays (not just the client's co-payment, counts toward spend-down). This includes 3 months before the month client applies for Medicaid.
- Unpaid medical bills (no time limit, can be very old bills, as long as they are viable meaning doctor can sue to collect the money).

Spousal Impoverishment:

The expense of nursing home care, which ranges from \$4,000 to \$6,000 a month or more, can rapidly deplete the lifetime savings of elderly couples. In 1988, Congress enacted provisions to prevent what has come to be called "spousal impoverishment," which can leave the spouse who is still living at home in the community (The "community spouse") with little or no income or resources. These provisions help ensure that this situation will not occur and that community spouses are able to live out their lives with independence and dignity. Spousal impoverishment protections have been extended to community spouses of individuals receiving Home and Community Based Services (HCBS) waiver or Medicaid managed long term care (MLTC) services.

Resource Eligibility: The spousal impoverishment provisions apply when one member of a couple (The "Medicaid spouse") enters a nursing facility or other medical institution and is expected to remain there for at least 30 days or if the individual is receiving HCBS waiver or MLTC services. When the couple applies

for Medicaid, an assessment of their resources is made. The couple's resources, regardless of ownership, are combined. The couple's home, (if the equity value is below \$828,000) household goods, an automobile, and burial funds are not included in the couple's combined resources. The result is the couple's combined countable resources. This amount is then used to determine the Spousal Share, which is one-half of the couple's combined resources.

To determine whether non-community spouse meets the state's resource standard for Medicaid, the following procedure is used: From the couple's combined countable resources, a Protected Resource Amount (PRA) is subtracted. The PRA is the greatest of:

- The Spousal Share, up to a maximum of \$119,220;
- An amount transferred to the community spouse for her/his support as directed by a court order; or
- An amount designated by a state hearing officer to raise the community spouse's protected resources up to the minimum monthly maintenance needs standard.

After the PRA is subtracted from the couple's combined countable resources, the remainder is considered available to the spouse residing in the medical institution as countable resources. If the amount of countable resources is below the State's resource standard, the individual is eligible for Medicaid. Once resource eligibility is determined, any resources belonging to the community spouse are no longer considered available to the spouse in the medical facility.

Income Eligibility: A Medicaid spouse may use all or part of his or her income to support the community spouse, depending on the spouse's own income. If the community spouse has his or her own income that is less than the "minimum monthly maintenance needs allowance" [MMMNA] (\$2,981/mo), then the community spouse may keep his/her own income plus enough of the Medicaid spouse's income to bring the total up to the MMMNA level. This is called the "*community spouse monthly income allowance*" (CSMIA).

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

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

NOTES:

MEDICARE SAVINGS PROGRAM 2016

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

Qualified Medicare Beneficiary Program (QMB):

- Pays for the Medicare Part A and/or Part B premiums.
- Pays for the Medicare Part A and/or Part B coinsurance and deductibles.
- An individual can be eligible for QMB only or for QMB and Medicaid.
- There is no resource test if applying for QMB only.
- QMBs may not be balanced billed, even if they are part of Medicare Advantage.
- QMBs have no retroactivity.
- Effective the first of the month after application.

QMB	Income Below
Single:	\$1010 per month
Couple:	\$1368 per month

Specified Low Income Medicare Beneficiary Program (SLIMB):

- Pays for the Medicare Part B premium only.
- Individuals can be eligible for SLIMB only or for SLIMB and Medicaid (with a spend-down).
- The applicant must have Medicare Part A in order to be eligible for the program.
- There is no resource test if applying for SLIMB only.
- SLIMBs are retro-active three months before the first of the month of application.

SLIMB	Income Below
Single:	\$1,208 per month
Couple:	\$1,622 per month

Qualified Individual (QI):

- This program pays for the Medicare Part B premium only. Individuals cannot be eligible for QI-1 and Medicaid.
- The applicant must have Medicare Part A.
- There is no resource test for this program.
- QIs can have three months of retroactivity. However, QI is not retroactive into previous calendar years.

QI	Income Below
Single:	\$1,357 per month
Couple:	\$1,823 per month

Qualified Disabled and Working Individual (QDWI):

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

QDWI	Income Below	Resources Below
Single:	\$ 1,980 per month	\$ 4,000
Couple:	\$ 2,670 per month	\$ 6,000



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

http://www.health.ny.gov/health_care/medicaid/program/update/savingsprogram/msapp.pdf

Proof of Income:	
Earned Income from Employer	Current paycheck/stubs (4 consecutive weeks) or letter from employer
Self-Employment Income	Current signed income tax return or record of earnings and expenses
Rental/Roomer-Boarder Income	Letter from roomer, boarder, tenant or check stub
Unemployment Benefits	Award letter/certificate, benefit check, correspondence from NYS Dept. of Labor Statement from pension/annuity.
Private Pensions/Annuities	Statement from pension/annuity
Social Security	Award letter/certificate, benefit check, correspondence from SSA
Child Support/Alimony	Letter from person providing support, letter from court, child support/alimony check stub
Worker's Compensation	Award letter, check stub
Veteran's Benefits	Award letter, benefit check stub, correspondence from VA
Military Pay	Award letter, check stub
Support from Family Members	Signed statement and/or letter from family member
Income from a trust	Trust document

Citizenship/Identity	
Identity	Copy of front and back of you or your spouse's Medicare cards
Citizenship	A copy of your Medicare card (also serves as a documentation of U.S. citizenship)
Immigrant/Lawful Permanent Resident (LPR)	Immigration documentation such as USCIS form I-551 "Green Card"

Residency/Home Address	
ID card with address	Postmarked non-window envelope, postcard, magazine label with name, address and date
Driver's license issued within past 6 months	Utility bill within last six months (gas, electric, cable), or correspondence from a govt. agency
School Record	

Health Insurance Premiums
Letter from Employer, Premium Statement or Pay Stub

Medicare Savings Program Budgeting

Earned Income

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

Unearned Income

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

Disregards

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

Disregard for Health Insurance Premiums

- Subtract the monthly premium for other insurances such as:
 - Medigap premiums
 - Medicare Advantage Month Premium (not including the part allocated to Part D)
 - Any remaining Part D premium that is “above the benchmark”
 - Long Term Care Insurance
 - Union Health Fund Premiums
 - Dental Insurance/Major Medical

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

Household Sizes:

Budget a “Household of ~~Two~~” for married couples living together (regardless of whether spouse is also aged, blind or disabled). Except:

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

Interest:

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

To see a copy of the NYS Department of Health's documentation on income, go to

http://www.health.ny.gov/health_care/medicaid/reference/mrg/inco.pdf

INCOME**UNEARNED**

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

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

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

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

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

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

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

MEDICARE SAVINGS PROGRAM
APPLICATION

(Please Print Clearly and Do Not Write In Dark Shaded Area)

APPLICANT	First Name _____	M.I. _____	Last Name _____	HOME PHONE
HOME ADDRESS	Street _____	Apt. _____	City _____	State _____ Zip Code _____ County _____
Is this a Shelter? Yes ___ No ___				
MAILING ADDRESS	Street/P.O. Box _____	Apt. _____	City _____	State _____ Zip Code _____ County _____
<i>(If different from above)</i>				

NAMES *(List your name first. Include aliases and maiden name)*

	First	M.I.	Last	Date of Birth	Sex	Social Security #	Race Ethnic Code
Self							
Spouse							
Child *							

If under 18 years of age. Attach extra sheet if necessary to list additional children.

Race/Ethnic affiliation codes:

B - Black, not of Hispanic origin **W** - White, not of Hispanic origin **H** - Hispanic **U** - Unknown
A - Asian or Pacific Islander **I** - American Indian/Alaskan Native **O** - Other

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) _____

APPLICANT'S MEDICARE INFORMATION Medicare # _____ *(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 INFORMATION, if applying Medicare # _____ *(From red and blue Medicare card)*
 Does spouse have Medicare Part A? ___ Yes ___ No Effective Date _____
 Does 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 \$ _____

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc.

Names of Applicant, Spouse, or Child under 18 <i>(Attach an extra sheet if necessary)</i>	Who Provides the Money? <i>(Name/source of income)</i>	What Amount? \$	How Often? <i>(weekly, two weeks, monthly)</i>

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

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. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Medicaid or if you conceal or fail to disclose facts that would effect the right of someone for whom you have applied to obtain or continue to receive Medicaid benefits; and such benefits must be used by the other person and not for yourself.
CHANGES: I agree to inform the agency promptly of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

SOCIAL SECURITY NUMBER (SSN): If you are applying for the Medicare Savings Program, you must report your SSN, unless you are a pregnant woman. 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.

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.

Applicant/Representative

Signature X _____ Date _____

Spouse Signature X _____ Date _____

Representative Address, Phone Number and Relationship _____

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program please sign on the following line.

I consent to withdraw my application _____ Date _____

SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION: X			DATE:		EMPLOYED BY:		
Eligibility Determined By Worker: _____ (DATE)				Eligibility Approved By: _____ (DATE)			
CENTRAL/OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NO	REUSE IND.	
CASE NAME		DISTRICT		REGISTRY NO.		VER.	
Effective Date _____ MA Disp. _____ Denial _____ Withdrawal _____				REASON CODE		PROXY: Yes No	

PLAN FINDER

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

- If the 'Confirmation' page displays with a 14-digit confirmation number, your enrollment has been saved. You should write down the confirmation number or print the confirmation page so that you can refer to it later, or when you want to call the plan or 1-800-MEDICARE. You can also use the "Email Your Confirmation" button to send an email containing all the information on the Confirmation page

Technical Problems: First contact NYSOFA HIICAP Staff at:

Heather Leddick – Heather.Leddick@aging.ny.gov 518-474-2401
Brenda LaMere – Brenda.LaMere@aging.ny.gov 518-474-6085

Planfinder technical issues must be completed on a Planfinder Intake Form (see page 71. This form will be sent to the Planfinder Network Team.

PUBLICATIONS

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

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

Medicare Plan Finder Intake Form

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

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

NOTES:

REPORTING

<https://shipnpr.acl.gov>

The following provides an overview of the three (3) required reports and their reporting periods:

- 1) **The Client Contact Form** - records all client contacts. Contacts can be made over the phone, in person, at the office or in a home, via postal mail, email or a fax transmittal.
- 2) **Public & Media Activity Form (PAM)** – The PAM captures the type and number of media activities -- radio and television shows, presentations, newsletters, etc., as well as the topics covered and their target audiences. Enter all public and media events online.

Effective April 1, 2014, **monthly** data entry and monthly uploads for client contact and public and media data are now required.

Client Contact CC and Public and Media PAM Data Entry and Data Upload Due Dates	
Dates of Contacts or Start Dates of Events	CC and PAM Entry or Data Upload Due Date
April	May 31 st
May	June 30 th
June	July 31 st
July	August 31 st
August	September 30 th
September	October 31 st
October	November 30 th
November	December 31 st
December	January 31 st
January	February 28 th
February	March 31 st
March	April 30 th

- 3) **Resource Report** -This report captures all of the resources (HIICAP and non-HIICAP funded) that have been used to assist Medicare beneficiaries. Reports can be emailed or faxed to NYSOFA.

Resource Report Period	Hard Copy e-mail to NYSOFA
April 2016 - March 2017	May 15 2017

Send Resource Reports to NYSOFA!! Do Not Enter Data into Shiptalk!!

Questions? Contact Helen Fang at 518-473-3002 or Helen.Fang@aging.ny.gov

NOTES:

CLIENT CONTACT FORM

*** Items marked indicate required fields ***

Client Identifier *

Client Identifier Used By Your Agency or State: _____

OR Client Identifier Auto-Assigned by NPR: _____

Client Name and Contact Information

Client First Name: _____ Representative First Name: _____

Client Last Name: _____ Representative Last Name: _____

Client Phone Number: (_____) - _____ - _____

Client Zip Code and County *

Zip Code of Client Residence * : _____ County of Client Residence: _____

Counselor and Agency *

Counselor * : _____ County of Counselor Location * : _____

Agency * : _____ ZIP Code of Counselor Location * : _____

Date of Contact * (MM/DD/YYYY) : _____ / _____ / _____

First vs Continuing Contact * First Contact for Issue Continuing Contact for Issue

How Did Client Learn About SHIP *

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> Previous Contact | <input type="checkbox"/> Presentations | <input type="checkbox"/> Another Agency | <input type="checkbox"/> Media | <input type="checkbox"/> Other |
| <input type="checkbox"/> CMS / Medicare | <input type="checkbox"/> Mailings | <input type="checkbox"/> Friend or Relative | <input type="checkbox"/> State Website | <input type="checkbox"/> Not Collected |

Method of Contact *

- | | | | |
|-------------------------------------|--|--------------------------------|---|
| <input type="checkbox"/> Phone Call | <input type="checkbox"/> Face to Face at Client's Home or Facility | <input type="checkbox"/> EMail | <input type="checkbox"/> Postal Mail or Fax |
|-------------------------------------|--|--------------------------------|---|

Client Age Group *

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> 64 or Younger | <input type="checkbox"/> 75 – 84 |
| <input type="checkbox"/> 65 – 74 | <input type="checkbox"/> 85 or Older |
| <input type="checkbox"/> Not Collected | |

Client Gender *

- | |
|--|
| <input type="checkbox"/> Female |
| <input type="checkbox"/> Male |
| <input type="checkbox"/> Not Collected |

Client Race – Ethnicity *

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Hispanic, Latino, or Spanish Origin | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> White, Non-Hispanic | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Some Other Race – Ethnicity |
| <input type="checkbox"/> Black, African American | <input type="checkbox"/> Chinese | <input type="checkbox"/> Samoan | <input type="checkbox"/> Not Collected |
| <input type="checkbox"/> Japanese American | <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Asian | |
| <input type="checkbox"/> Korean | | | |

Client Primary Language *

- | | | |
|--|---|--|
| <input type="checkbox"/> Primary Language Other Than English | <input type="checkbox"/> English is Client's Primary Language | <input type="checkbox"/> Not Collected |
|--|---|--|

Client Monthly Income *

- | | | |
|---|---|--|
| <input type="checkbox"/> Below 150% FPL | <input type="checkbox"/> At or Above 150% FPL | <input type="checkbox"/> Not Collected |
|---|---|--|

Client Assets *

- | | | |
|---|---|--|
| <input type="checkbox"/> Below LIS Asset Limits | <input type="checkbox"/> Above LIS Asset Limits | <input type="checkbox"/> Not Collected |
|---|---|--|

Receiving or Applying for Social Security Disability or Medicare Disability *

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Collected |
|------------------------------|-----------------------------|--|

Prescription Drug Assistance * (Select All that Apply)

Medicare Prescription Drug Coverage (Part D)

- 1 – Eligibility / Screening
- 2 – Benefit Explanation
- 3 – Plans Comparison
- 4 – Plan Enrollment / Disenrollment
- 5 – Claims / Billing
- 6 – Appeals / Grievances
- 7 – Fraud and Abuse
- 8 – Marketing / Sales Complaints or Issues
- 9 – Quality of Care
- 10 – Plan Non-Renewal

Medicare Advantage (HMO, POS, PPO, PFFS, SNP, MSA, Cost)

- 27 – Eligibility / Screening
- 28 – Benefit Explanation
- 29 – Plans Comparison
- 30 – Plan Enrollment / Disenrollment
- 31 – Claims / Billing
- 32 – Appeals / Grievances
- 33 – Fraud and Abuse
- 34 – Marketing / Sales Complaints or Issues
- 35 – Quality of Care
- 36 – Plan Non-Renewal

Prescription Drug Assistance Continued * (Select All that Apply)		<i>Medicare Supplement / Select</i> <input type="checkbox"/> 37 – Eligibility / Screening <input type="checkbox"/> 38 – Benefit Explanation <input type="checkbox"/> 39 – Plans Comparison <input type="checkbox"/> 40 – Claims / Billing <input type="checkbox"/> 41 – Appeals / Grievances <input type="checkbox"/> 42 – Fraud and Abuse <input type="checkbox"/> 43 – Marketing / Sales Complaints or Issues <input type="checkbox"/> 44 – Quality of Care <input type="checkbox"/> 45 – Plan Non-Renewal	
<i>Part D Low Income Subsidy (LIS / Extra Help)</i> <input type="checkbox"/> 11 – Eligibility / Screening <input type="checkbox"/> 12 – Benefit Explanation <input type="checkbox"/> 13 – Application Assistance <input type="checkbox"/> 14 – Claims / Billing <input type="checkbox"/> 15 – Appeals / Grievances		<i>Medicaid</i> <input type="checkbox"/> 46 – Medicare Savings Program (MSP) Screening (QMB, SLMB, QI) <input type="checkbox"/> 47 – MSP Application Assistance <input type="checkbox"/> 48 – Medicaid (SSI, Nursing Home, MEPD, Elderly Waiver) Screening <input type="checkbox"/> 49 – Medicaid Application Assistance <input type="checkbox"/> 50 – Medicaid / QMB Claims <input type="checkbox"/> 51 – Fraud and Abuse	
<i>Other Prescription Assistance</i> <input type="checkbox"/> 16 – Union / Employer Plan <input type="checkbox"/> 17 – Military Drug Benefits <input type="checkbox"/> 18 – Manufacture Programs <input type="checkbox"/> 19 – State Pharmaceutical Assistance Programs <input type="checkbox"/> 20 – Other : Specify Other _____		<i>Others</i> <input type="checkbox"/> 52 – Long Term Care (LTC) Insurance <input type="checkbox"/> 53 – LTC Partnership <input type="checkbox"/> 54 – LTC Other <input type="checkbox"/> 55 – Military Health Benefits <input type="checkbox"/> 56 – Employer / Federal Employee Health Benefits (FEHB) <input type="checkbox"/> 57 – COBRA <input type="checkbox"/> 58 – Other Health Insurance <input type="checkbox"/> 59 – Other : Specify Other _____	
Total Time Spent on This Contact *		____ Hours ____ Minutes	
Status *	<input type="checkbox"/> General Information and Referrals	<input type="checkbox"/> Detailed Assistance – In Progress <input type="checkbox"/> Detailed Assistance – Fully Completed	<input type="checkbox"/> Problem Solving / Problem Resolution – In Progress <input type="checkbox"/> Problem Solving / Problem Resolution – Fully Completed
Nationwide Special Use Fields – FOR MIPPA AND FIDA			
1.MIPPA Client (Select 1 2 or 3) : _____ 2.Dual Ref in Srce (Select 1 2 3 4 5 6 or 7) : _____ 3.Enrol Broker Asst (Select Yes or No) : _____ 4.Letter Stat Mcaid (Select Yes or No) : _____ 5.Managed Care Optn (Select Yes or No) : _____		6.Enrollment Assist (Select Yes or No) : _____ 7.Other Mcare Issue (Select Yes or No) : _____ 8.Pubs Other Mater (Select Yes or No) : _____ 9.Dual Ref Out (Select 1 2 3 4 5 6 7 or 8) : _____ 10.Bene Disposition (Select 1 2 3 4 or 5) : _____	
Comments 			

Public And Media Events

*** Items marked indicate required fields ***

Agency Name * : _____

Please Add at Least One Presenter or Contributor Name and Corresponding Total Hours Spent *

Presenter or Contributor (First, Last) Name *	Affiliation	Total Hours Spent on Activity Per Presenter – Contributor *

- Can Enter up to 25 Presenters/Staff Contributors Per Event – Record Any Additional Presenters on Back of Form

Activity or Event * (***At Least One Activity or Event is required**)

1. Interactive Presentation to Public, Face to Face In Person

Estimated Number of Attendees: _____

Estimated Persons Provided Enrollment Assistance: _____

2. Booth or Exhibit, At Health Fair, Senior Fair, or Special Event

Estimate Number of Direct Interactions with Attendees: _____

Estimate Persons Provided Enrollment Assistance: _____

3. Dedicated Enrollment Event Sponsored by SHIP or in Partnership

Estimate Number of Persons Reached at Event Regardless of Enroll Assistanes: _____

Estimate Number Persons Provided Any Enrollment Assistance: _____

Estimate Number Provided Enrollment Assistance with Part D: _____

Estimate Number Provided Enrollment Assistance with LIS: _____

Estimate Number Provided Enrollment Assistance with MSP: _____

Estimate Number Provided Enrollment Assistance Other Medicare Program: _____

4. Radio Show, Live or Taped, Not a Public Service Announce or Ad

Estimate Number of Listeners Reached: _____

5. TV or Cable Show, Live or Taped, Not a Public Service Announce or Ad

Estimate Number of Viewers: _____

6. Electronic Other Activity, PSAs, Electronic Ads, Crawls, Video Conf, Web Conf, Web Chat

Estimate Persons Viewing or Listening to PSA, Electronic Ad, Crawl Across Entire Campaign, Video Conf, Web Conf, Web Chat: _____

7. Print Other Activity, Newspaper, Newsletter, Pamphlets, Fliers, Posters, Target Mailings

Estimate Persons Reading Article, Newsletter, Ad or Piece of Targeted Mail or Other Print Across Entire Campaign: _____

Activity Date * (MM/DD/YYYY)

State Date of Activity: * (___ / ___ / _____) End Date of Activity * (___ / ___ / _____)

Event Details *	
Event or Group Name *: _____	Contact First Name: _____ Contact Last Name: _____ Contact Phone Number: (____) - ____ - _____
State of Event *: _____	City of Event *: _____
County of Event *: _____	Street Address of Event* : _____
Zip Code of Event *: _____	
Topic Focus – Select All That Apply *	Target Audience – Select All That Apply *
<input type="checkbox"/> 1 – Medicare Parts A and B <input type="checkbox"/> 2 – Plan Issues – Non Renewal, Termination, Employer-COBRA <input type="checkbox"/> 3 – Long-Term Care <input type="checkbox"/> 4 – Medigap – Medicare Supplements <input type="checkbox"/> 5 – Medicare Fraud and Abuse <input type="checkbox"/> 6 – Medicare Prescription Drug Coverage – Assistance – PDP / MA-PD <input type="checkbox"/> 7 – Other Prescription Drug Coverage – Assistance <input type="checkbox"/> 8 – Medicare Advantage <input type="checkbox"/> 9 – QMB – SLMB – QI <input type="checkbox"/> 10 – Other Medicaid <input type="checkbox"/> 11 – General SHIP Program Information <input type="checkbox"/> 12 – Medicare Preventive Services <input type="checkbox"/> 13 – Low Income Assistance <input type="checkbox"/> 15 – Volunteer Recruitment <input type="checkbox"/> 16 – Partnership Recruitments <input type="checkbox"/> 17 – Other Topics – Specify Others: _____	<input type="checkbox"/> 1 – Medicare Pre-Enrollees – Age 45-64 <input type="checkbox"/> 2 – Medicare Beneficiaries <input type="checkbox"/> 3 – Family Members – Caregivers of Medicare Beneficiaries <input type="checkbox"/> 4 – Low-Income <input type="checkbox"/> 5 – Hispanic, Latino or Spanish Origin <input type="checkbox"/> 6 – White, Non – Hispanic <input type="checkbox"/> 7 – Black, African American <input type="checkbox"/> 8 – American Indian or Alaska Native <input type="checkbox"/> 9 – Asian Indian <input type="checkbox"/> 10 – Chinese <input type="checkbox"/> 11 – Filipino <input type="checkbox"/> 12 – Japanese <input type="checkbox"/> 13 – Korean <input type="checkbox"/> 14 – Vietnamese <input type="checkbox"/> 15 – Native Hawaiian <input type="checkbox"/> 16 – Guamanian or Chamorro <input type="checkbox"/> 17 – Samoan <input type="checkbox"/> 18 – Other Asian <input type="checkbox"/> 19 – Other Pacific Islander <input type="checkbox"/> 20 – Some Other Race-Ethnicity <input type="checkbox"/> 21 – Disabled <input type="checkbox"/> 22 – Rural <input type="checkbox"/> 23 – Employer- Related Group <input type="checkbox"/> 24 – Mental Health Professionals <input type="checkbox"/> 25 – Social Work Professionals <input type="checkbox"/> 26 – Dual Eligible Groups <input type="checkbox"/> 27 – Partnership Outreach <input type="checkbox"/> 28 – Presentations to Groups in Languages Other Than English <input type="checkbox"/> 29 – Other Audiences – Specify Others: _____
Nationwide and Special Use Fields – If applicable	
1.MIPPA Event (Select 1 2 or 3) : _____	
2.Dis Duals MM FAM (Select Yes or No) : _____	
3.Broker Asst MM FAM (Select Yes or No) : _____	
Comments	

RESOURCE REPORT

OMB No. 0938-0850

Complete Only One RR Form for the Entire State. Do Not Submit Sponsoring-Agency-Level or Within-State-Regional Resource Reports.
 All Person Counts Should Reflect Active Counselors, Coordinators, Other Staff as of the End of Each Grant Year (31 March).
 The Unique Count of Counselors Attending Any Update Training During the Grant Year Cannot Exceed the Grand Total Number of Counselors.

12 Month Period for This Report	State Code	State Grantee Name
From: 04 / 01 / <input type="text"/> To: 03 / 31 / <input type="text"/>	<input type="text"/>	<input type="text"/>

Person Completing Report	Title	Telephone Number
<input type="text"/>	<input type="text"/>	(<input type="text"/>) <input type="text"/> - <input type="text"/>

Section 1	State Office	All Other Local and Field Sites	Total	Section 2	Total
Number of Active Counselors And Hours As of 31 March				Number of Local Coordinators / Sponsors and Hours As of 31 March	
A. Number of Volunteer Counselors				A. Number of Volunteer (Unpaid) Coordinators	
B. Number of SHIP-Paid Counselors				B. Number of SHIP-Paid Coordinators	
C. Number of In-Kind-Paid Counselors				C. Number of In-Kind-Paid Coordinators	
Total Number of Counselors - A+B+C				Total Number of Coordinators - A+B+C	
D. Volunteer Counselor Hours				D. Volunteer (Unpaid) Coordinator Hours	
E. SHIP-Paid Counselor Hours				E. SHIP-Paid Coordinator Hours	
F. In-Kind-Paid Counselor Hours				F. In-Kind-Paid Coordinator Hours	
Total Counselor Hours - D+E+F				Total Coordinator Hours - D+E+F	

Section 3	State Office	All Other Local and Field Sites	Total	Section 4 - Counselor Trainings	Total
Number of Other Paid and Volunteer Staff And Hours As of 31 March				A. Number of Initial Trainings for New SHIP Counselors	
A. Number of Volunteer Other Staff				B. Number of New SHIP Counselors Attending Initial Trainings	
B. Number of SHIP-Paid Other Staff				C. Total Number of Counselor Hours in Initial Trainings	
C. Number of In-Kind-Paid Other Staff				D. Number of Update Trainings for SHIP Counselors	
Total Number of Other Staff - A+B+C				E. Number of SHIP Counselors Attending Update Trainings	
D. Volunteer Other Staff Hours				F. Total Number of Counselor Hours in Update Trainings	
E. SHIP-Paid Other Staff Hours				Note Item E should represent the number (unduplicated) of counselors who attended at least one update training during the full 12 month period. Please do not count a counselor more than once, even if he/she attended multiple update trainings.	
F. In-Kind-Paid Other Staff Hours					
Total Other Staff Hours - D+E+F					

Section 5 - Number of Total Active Counselors (SHIP-Paid, In-Kind-Paid, and Volunteer Counselors) with the Following Characteristics

<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr><th colspan="2">Years of SHIP Service</th></tr> </thead> <tbody> <tr><td>1</td><td>Less Than 1 Year</td></tr> <tr><td>2</td><td>1 Year Up to 3 Years</td></tr> <tr><td>3</td><td>3 Years Up to 5 Years</td></tr> <tr><td>4</td><td>More Than 5 Years</td></tr> <tr><td>9</td><td>Not Collected</td></tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr><th colspan="2">Counselor Age</th></tr> </thead> <tbody> <tr><td>1</td><td>Less Than 65 Years of Age</td></tr> <tr><td>2</td><td>65 Years or Older</td></tr> <tr><td>9</td><td>Not Collected</td></tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr><th colspan="2">Counselor Gender</th></tr> </thead> <tbody> <tr><td>1</td><td>Female</td></tr> <tr><td>2</td><td>Male</td></tr> <tr><td>9</td><td>Not Collected</td></tr> </tbody> </table>	Years of SHIP Service		1	Less Than 1 Year	2	1 Year Up to 3 Years	3	3 Years Up to 5 Years	4	More Than 5 Years	9	Not Collected	Counselor Age		1	Less Than 65 Years of Age	2	65 Years or Older	9	Not Collected	Counselor Gender		1	Female	2	Male	9	Not Collected	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr><th colspan="2">Counselor Race - Ethnicity</th></tr> </thead> <tbody> <tr><td>1</td><td>Hispanic, Latino, or Spanish Origin</td></tr> <tr><td>2</td><td>White, Non-Hispanic</td></tr> <tr><td>3</td><td>Black, African American</td></tr> <tr><td>4</td><td>American Indian or Alaska Native</td></tr> <tr><td>5</td><td>Asian Indian</td></tr> <tr><td>6</td><td>Chinese</td></tr> <tr><td>7</td><td>Filipino</td></tr> <tr><td>8</td><td>Japanese</td></tr> <tr><td>9</td><td>Korean</td></tr> <tr><td>10</td><td>Vietnamese</td></tr> <tr><td>11</td><td>Native Hawaiian</td></tr> <tr><td>12</td><td>Guamanian or Chamorro</td></tr> <tr><td>13</td><td>Samoan</td></tr> <tr><td>14</td><td>Other Asian</td></tr> <tr><td>15</td><td>Other Pacific Islander</td></tr> <tr><td>16</td><td>Some Other Race-Ethnicity</td></tr> <tr><td>17</td><td>More Than One Race-Ethnicity</td></tr> <tr><td>99</td><td>Not Collected</td></tr> </tbody> </table>	Counselor Race - Ethnicity		1	Hispanic, Latino, or Spanish Origin	2	White, Non-Hispanic	3	Black, African American	4	American Indian or Alaska Native	5	Asian Indian	6	Chinese	7	Filipino	8	Japanese	9	Korean	10	Vietnamese	11	Native Hawaiian	12	Guamanian or Chamorro	13	Samoan	14	Other Asian	15	Other Pacific Islander	16	Some Other Race-Ethnicity	17	More Than One Race-Ethnicity	99	Not Collected	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr><th colspan="2">Counselor Disability</th></tr> </thead> <tbody> <tr><td>1</td><td>Disabled</td></tr> <tr><td>2</td><td>Not Disabled</td></tr> <tr><td>9</td><td>Not Collected</td></tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr><th colspan="2">Counselor Speaks Another Language</th></tr> </thead> <tbody> <tr><td>1</td><td>Language Other Than English</td></tr> <tr><td>2</td><td>English Speaker Only</td></tr> <tr><td>9</td><td>Not Collected</td></tr> </tbody> </table>	Counselor Disability		1	Disabled	2	Not Disabled	9	Not Collected	Counselor Speaks Another Language		1	Language Other Than English	2	English Speaker Only	9	Not Collected
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Form CMS-10028C (07/13)

NOTES:

UNINSURED

Helpful Tip!

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

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

American Dental Centers – This is a membership group – annual fee includes two dental exams, two treatment plans, x-rays up to full series (once a year) and cleaning - prophylaxis (one per year). Other services are discounted to members. Must use their dental offices. Family rates are also available. 1-888-764-5320

Caring Voice Coalition (CVC) - In order to qualify for financial assistance through CVC, you must be diagnosed with one of the following conditions: pulmonary hypertension, idiopathic pulmonary fibrosis, or Alpha 1. CVC may be able to help pay for some of the costs associated with prescription drugs for certain medical conditions. To apply, call 1-888-267-1440 or visit: <http://www.caringvoice.org/2011/09/financial-assistance/>

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

Community Health Advocates (CHA) – This program is similar to HIICAP! They are a great resource if you would like to refer a person, especially for those who do not qualify for Medicare! Contact cha@cssny.org 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: www.opm.gov/retire



GoodRx – Save up to 80% on prescription drugs at most U.S. pharmacies, 1-888-277-3911.

The HealthWell Foundation – Helps pay your drug copays if you have insurance or your monthly premium. You must be diagnosed with Acute Porphyria, Anemia associated with Chronic Renal Insufficiency/Chronic renal Failure, Chemotherapy Induced Anemia/Chemotherapy Induced Neutropenia, and other systems. To find out if you qualify, call 1-800-675-8416 or visit: healthwellfoundation.org

LawHelp.Org/NY – Helps low income New Yorkers solve legal problems such as consumer, disability, housing, immigration and taxes. More information can be found at: www.lawhelp.org/NY/

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

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

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

Partnership for Prescription Assistance - This group brings together America's pharmaceutical companies, doctors, and health care providers, patient advocacy organizations and community groups to help qualifying patients who lack prescription coverage get the medicines they need through the public or private program. Through this site, the Partnership for Prescription Assistance offers a single point of access to more than 475 public and private patient assistance programs, including more than 180 programs offered by pharmaceutical companies. To find out more information, call 1-888-04PPA- NOW (1-888-477-2669) or visit: www.pparx.org/Intro.php

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

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

Pfizer Medicines – Pfizer is a patient assistance program that makes locating services more accessible. Through their Program Finder tool, <http://www.pfizerhelpfulanswers.com/pages/misc/Default.aspx> , uninsured and underinsured patients who qualify are able to search for medicines free of charge or at a savings and receive reimbursement services.

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

Rx Outreach – No age limit. You must have income less than \$35,640 (\$48,060 for married couples). No enrollment fees. To find out more information, call 1-800-769-3880 or www.rxoutreach.com

TRICARE – is a program for military retirees who have served at least 20 years. You must be registered with Defense Enrollment. No enrollment fees and low-cost Rx. To find out more information, call 877-874-2273

VA Health Benefits Service Center – Veteran must have been honorably discharged from the military. Must enroll with VA and be seen by VA doctor. To find out more information, call 1-877-222-8387.

Vision Services (Low Cost):

New York State Commission for the Blind – Information on programs for older adults: 1-866-871-3000.

Lighthouse International – worldwide organization dedicated to overcoming vision impairment through rehabilitation, education, research and advocacy. 1-8001-284-4422, www.lighthouseguild.org

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

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

NOTES:

EPIC OUTREACH CONTACTS

General Email Inquiries: epicoutreach.inquiries@xerox.com		
Contact/Name	Territories/Counties	Telephone/Email
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Shirley Belotte	<u>Capital District & Central New York</u> : Albany, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Rensselaer, Saratoga Schenectady and Schoharie Counties	
Gabrielle Dotterweich	<u>Central New York</u> : Broome Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison Oneida, Onondaga, Oswego, and Otsego Counties	716-264-9815 Gabrielle.dotterweich@xerox.com
Laura Mulvihill	<u>Hudson Valley</u> : Orange, Putnam, Rockland, Sullivan, Ulster and Westchester Counties	(518) 312-1361 Laura.mulvihill@xerox.com
Gabrielle Dotterweich	<u>Western New York</u> : Allegany, Cattaraugus, Cayuga, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming and Yates Counties	716-264-9815 Gabrielle.dotterweich@xerox.com
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NOTES:

HIICAP COORDINATORS LIST

Area Agency on Aging	Subcontractor
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ALLEGANY	
<p>Anita Mattison, Coordinator Allegany County Office for the Aging 6085 State Route 19N Belmont, NY 14813 Helpline 585-268-9390 Fax: 585-268-9657 Email: MattisA@alleganyco.com</p>	
BROOME	
<p>Jaime Kelly Broome County Office for the Aging Governmental Plaza, 4th Floor PO Box 1766 Binghamton, NY 13902-1766 607-778-2922 Fax: 607-778-2316 Email: jkelly2@co.broome.ny.us</p>	<p>Jane Talbot, Coordinator Action for Older Persons, Inc. 200 Plaza Drive Suite B Vestal, NY 13850 HIICAP Helpline 607-722-1251 Fax: 607-722-1293 Email: Jtalbot@actionforolderpersons.org</p>
CATTARAUGUS	
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CAYUGA	
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CHAUTAUQUA	
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ST. REGIS MOHAWK

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SUFFOLK	
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SULLIVAN	
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TIOGA	
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TOMPKINS	
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ULSTER	
<p>Robert Meci, Coordinator Ulster County Office for the Aging 1003 Development Court Kingston, NY 12401 Helpline 845-340-3456 Fax: 845-340-3583 Email: rmec@co.ulster.ny.us</p>	<p>- - - -</p>

WARREN

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WASHINGTON

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WAYNE

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WESTCHESTER

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YATES

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NOTES:

New York State's 2016-2017 Medicare Consumer Advocacy Project

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

Community Service Society
Serves: All of New York State
633 Third Avenue, 10th Floor
New York, NY 10017
212-614-5353
1-888-614-5353

Empire Justice Center
Serves: Upstate and Long Island
119 Washington Avenue
Albany, NY 12210
1-800-635-0355 x112
Empire Subcontracts With



The Legal Aid Society
Western NY Serves: All of New York State
199 Water Street
New York, NY 10038
1-888-500-2455 (upstate)
1-212-577-3575 (NYC area)

Legal Services for the Elderly -
Serves: Western New York
237 Main Street, Suite 1015
Buffalo, NY 14203-2717
716-853-3087

Medicare Rights Center
Serves: All of New York State
520 Eighth Avenue, North Wing 3rd Floor
New York, NY 10018
1-800-333-4114 (consumer)
1-800-480-2060 (HIICAPs)

New York Legal Assistance Group
Serves: NYC Area Only
450 West 33rd Street, 11th Floor
New York, NY 10001
212-613-5053

Statewide Senior Action (New York)
Serves: All of New York State
275 State Street
Albany, NY 12210
1-800-333-4374

NOTES:

CONTACT NUMBERS FOR PLANS IN NEW YORK STATE

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

Organization Name	Plan Name	Phone Number
Aetna	Aetna Medicare Rx Plans	866-459-3999
American Progressive	Today's Options	860-799-7135 Call provider line
CVS Caremark	CVS Caremark Plans	866-490-2098 x1
CIGNA	CIGNA Medicare Rx Plans	800-688-2187
Emblem Health	GHI PDP and HIP Plans	866-577-7300 Customer service
Empire Blue Cross Blue Shield	<u>Medicare Advantage Plans Only:</u> MediBlue Plans HMO Essential, Plus, Select PPO Essential Plus	866-796-4233 or 4236
Express Scripts	Express Scripts	800-846-4917
HealthFirst	HealthFirst Medicare Advantage	888-260-1010
Humana	Humana	888-666-2902
Independent Health	Independent Health	716-635-3595
Silver script	Silverscript Prescription Plans	888-831-3049
Unicare	MedicareRx Rewards Standard and Value Plans	866-796-4233
United Health Group	AARP Medicare Rx Plans PDPs Only	800-322-6761, and 866-507-9609
WellCare Health Plans	All Medicare Advantage and Prescription Drug Plans	866- 675-8574

NOTES:

SOCIAL SECURITY OFFICES
www.socialsecurity.gov
Toll-Free 1-800-772-1213

Albany County Area Social Security RM 430 Federal Bldg. 11 A Clinton Avenue Albany, NY 12207 Local Number - 1-866-253-9183	Broome County Area Social Security 2 Court St. Suite 300 Binghamton, NY 13901 Local Number 1-866-964-3971
Cattaraugus county Area Social Security 175 N. Union Street Suite 6 Olean, NY 14760 Local Number 1-877-319-5773	Chautauqua County Area Social Security 321 Hazeltine Avenue Jamestown, NY 14701 Local Number 1-877-319-3079
Chemung County Area Social Security Suite 201 100 West Church Street Elmira, NY 14901 Local Number 1-866-964-1715	Clinton County Area Social Security Suite 230 Plattsburgh, NY 12901 Local Number 1-866-296-8271
Columbia County Area Social Security 747 Warren Street Hudson, NY 12534 Local Number 1-877-828-1691	Dutchess County Area Social Security Vassar Main Building - 332 Main Street Poughkeepsie, NY 12601 Local Number 1-877-405-6747
Erie County Area Social Security Suite 100 186 Exchange Street Buffalo, NY 14204	Fulton County Area Social Security 13 N. Arlington Avenue Gloversville, NY 12078 Local Number 1-888-528-9446
Genesee County Area Social Security 571 East Main Street Batavia, NY 14020 Local Number 1-866-931-7103	Jefferson County Area Social Security 156 Bellew Ave. South Watertown, NY 13601 Local Number 1-866-627-6995
Monroe County Area Social Security 100 Chestnut Street Suite 1400 Rochester, NY 14604	Nassau County Area Social Security 84 North Main Street Freeport, NY 11520 Local Number no number available
New York City Social Security Room 120, 31st Floor 26 Federal Plaza New York, NY 10278	Niagara County Area Social Security 6540 Niagara Falls Blvd. Niagara Falls, NY 14304 Local Number 1-877-480-4992

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

Local Departments of Social Services

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

162 Washington Avenue, Albany, New York 12210

Allegany County DSS - 585-268-9622

7 Court St, Belmont, New York 14813-1077

Broome County DSS - 607-778-8850

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

Cattaraugus County DSS - 716-373-8065

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

Cayuga County DSS -315-253-1011

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

Chautauqua County DSS - 716-753-4421

Hall R. Clothier Building, Mayville, New York 14757

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

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

Chenango County DSS - 607-337-1500

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

Clinton County DSS - 518-565-3300

13 Durkee St, Plattsburgh, New York 12901-2911

Columbia County DSS - 518-828-9411/12

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

Cortland County DSS - 607-753-5248

60 Central Avenue, Cortland, New York 13045-5590

Delaware County DSS - 607-832-5300

111 Main St, Delhi, New York 13753

Dutchess County DSS - 845-486-3000

60 Market St, Poughkeepsie, New York 12601-3299

Erie County DSS - 716-858-8000

95 Franklin St, Buffalo, New York 14202-3959

Essex County DSS - 518-873-3441

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

Franklin County DSS - 518-481-1808

355 W. Main St, Malone, New York 12953

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

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

Genesee County DSS - 585-344-2580

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

Greene County DSS - 518-943-3200

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

Hamilton County DSS - 518-648-6131

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

Herkimer County DSS - 315-867-1291

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

Jefferson County DSS - 315-782-9030

250 Arsenal St, Watertown, New York 1360

Lewis County DSS - 315-376-5400

PO Box 193, Lowville, New York 13367

Livingston County DSS - 585-243-7300

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

Madison County DSS - 315-366-2211

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

Monroe County DSS - 585-753-2740

111 Westfall Rd, Rochester, New York 14620-4686

Montgomery County DSS - 518-853-4646

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

Nassau County DSS - 516-227-7474, Main # 227-8519

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

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

Human Resources Administration

Niagara County DSS - 716-439-7600

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

Oneida County DSS - 315-798-5733 Main # 315-798-5632 Medicaid

800 Park Avenue, Utica, New York 13501-2981

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

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

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

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

Orange County DSS - 845-291-4000

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

Orleans County DSS - 585-589-7000

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

Oswego County DSS - 315-963-5000

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

Otsego County DSS - 607-547-1700

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

Putnam County DSS - 845-808-1500

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

Rensselaer County DSS - 518-266-7970

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

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

Building L, Sanatorium Road, Pomona, New York 10970

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

152 West High St, Ballston Spa, New York 12020

Schenectady County DSS - 518-388-4470

797 Broadway, Schenectady, New York 12308-1812

Schoharie County DSS - 518-295-8334

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

Schuyler County DSS - 607-535-8303

323 Owego St, Montour Falls, New York 14865

Seneca County DSS - 315-539-1800

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

St. Lawrence County DSS - 315-379-2111

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

St. Regis Mohawk Tribe 518-358-2272

412 State Rte. 37 Akwesasne NY 13655

Steuben County DSS - 607-776-7611

3 East Pulteney Square, Bath, New York 14810

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

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

New App for Medicaid/Assist

- R'head: 631-852-3710

- H'pauge: 631-853-8730

Open Cases for Medicaid/Assist

- R'head: 631-852-3570

- H'Pauge: 631-853-8765

Sullivan County DSS – 845-292-0100

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

Tioga County DSS - 607-687-8300

PO Box 240, Owego, New York 13827

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

320 West State St, Ithaca, New York 14850

Ulster County DSS - 845-334-5000

1061 Development Court, Kingston, New York 12401-1959

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

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

Washington County DSS - 518-746-2300

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

Wayne County DSS - 315-946-4881

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

Westchester County DSS - 914-995-3333

85 Court St, White Plains, New York 10601

Wyoming County DSS - 585-786-8900

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

Yates County DSS - 315-536-5183

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

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**Health Insurance
Information, Counseling
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