Informational Update Vol 9 # 9 (December 19, 2018)

1. **Social Security Letter** – At the end of November, you should have received a letter from Social Security (known as the SSA letter) indicating your 2019 Social Security benefit amount before and after deductions. The benefit amount was based on your income in 2017. Other factors that played a role in this amount included 1) a 2.8 percent COLA increase before deductions, 2) an increase in the deductions for the standard amount and income-related monthly adjustment amount (IRMAA) for Medicare Part B, and 3) a DECREASE in the deductions for Medicare Part D IRMAA.

A new income bracket for 2019 Medicare Part B and Part D IRMAA deductions has been added. In 2018, there were 5 income brackets. For 2019, there will be a 6th for people who make over $$750,000.

Please note the first page of the SSA letter contains 4 bullets. The first one shows how much your SS benefit for 2019 is before deductions, if you are collecting social security. The second shows the 2019 deductions for Medicare Part B for the standard amount and for IRMAA (if not eligible for 2019 IRMAA, IRMAA deduction should be 0). If you have an IRMAA deduction (which would be listed right under the standard amount deduction), then you ARE eligible for 2019 IRMAA reimbursement. However, you DO NOT apply for it now. You must wait until you receive your 2019 standard amount reimbursement (will receive it automatically most likely in June 2020) when the 2019 IRMAA application will be first available.

The 3rd bullet shows the 2019 deduction for Part D IRMAA. If you have an IRMAA deduction for Part B then you will also have one for Part D. Please note that Part D IRMAA is NOT reimbursable.

It is imperative that you keep your 2019 SSA letter in a safe place. You will need to include it in your application package when you file for 2019 Part B IRMAA.

2. Payment of Medicare Part B Premium – Most Medicare members have their Part B premium electronically deducted from their Social Security Check.

However, if you are not collecting Social Security (you may be waiting until you are old enough to receive full payment) you will receive a bill called "Notice of Medicare Premium Payment Due" (CMS-500). You can pay this bill by 1) using your bank's online bill payment service, 2) signing up for Medicare Easy Pay, a free service that automatically deducts the premium payments from your savings or checking account each month, or 3) paying by check, money order or credit card. Check or money order is sent to:

Medicare Premium Collection Center

P.O. Box 790355

St. Louis, MO 63179-0355

If you use a credit card you will have to complete the bottom portion of the Medicare bill, sign it and send it to the above address.

3. Drug Tiers

Prescription drugs are placed into different tiers to lower drug costs. Generally, a Medicare drug plan has 3 or 4 tiers; Emblem Health has 4 tiers.

· Tier 1 – generic drugs - generally have the lowest co-payment.

· Tier 2 – preferred or brand-name prescription drugs - have a medium co-payment.

· Tier 3 – non-preferred drugs - brand-name drugs with a higher co-payment

· Tier 4 – specialty drugs - highest co-payment, very high cost prescription drugs.

Sometimes your doctor may feel you need a prescription drug in a higher, more expensive tier, instead of a similar one in a lower tier. In this instance, you can file an exception with your Part D plan, like Emblem Health, asking that the drug be placed on a lower tier. Also, there are pharmacies called preferred pharmacies that

work with your plan to lower the cost of prescription drugs. Finally, the price you pay may depend on whether you use a mail-order pharmacy, like Express Scripts or whether you request a 30 or 90 day supply. If you are taking a tier 4 drug, you can only request a 30 day supply.

Informational Update Vol 9 #8 (November 2018)

1.Medicare Part B 2017 IRMAA & Differential Reimbursement

Eligible members who have applied for 2017 IRMAA in a timely manner should have received two (2) checks last month: one for the 2017 IRMAA reimbursement and the second for the differential reimbursement ($300). If you do direct deposit or Electronic Fund Transfer (EFT) your checks were directly deposited into your bank account. If you do not do EFT or direct deposit, your checks were mailed to your home.

What is Differential Reimbursement (DR)?

Eligible members received their standard Medicare Part B 2017 reimbursement (and Medicare eligible dependent, if any), sometime last April. The amount was based on a monthly Part B premium of $109. If you paid that amount you are NOT eligible for the DR. However, most eligible members paid $134 per month. If you did, you were owed the difference between $134 & $109 ($25) times 12 ($300), which you should have received as mentioned above. Exception: If you went on Medicare in 2016 or later, your standard reimbursable was based on the full amount of $134. Therefore, you are not eligible for the DR.

There is also a group of people who were not eligible for 2017 IRMAA or did not collect Social Security, but were eligible for the DR because their monthly premium for Part B was $134. If they filed a special differential reimbursement form, they should have received the $300.

Can I Still Apply For 2017 IRMAA or the Differential Reimbursement?

Absolutely! If you are eligible for 2017 IRMAA, download the 2017 IRMAA application from the CSA Welfare Fund website (www.csawf.org). Just complete the application and submit along with the proper documentation to the Office of Labor Relations (OLR). The address is on the application. Eventually, you will get your IRMAA reimbursement as well as your DR reimbursement.

If you are only eligible for the DR and not IIRMAA, download the special DR form from the Fund website and fill out only the applicable parts. Submit the completed application to the OLR.

2 2. Shingles Shot

I have received numerous inquiries about the shingles shot concerning why some pay more than others or pay nothing at all, and the procedure for receiving the shingles shot. The answer and procedure can be broken down into two categories:

Non-Medicare Members

a) Get the vaccine and shot from a GHI participating pharmacy (Ex: Publix or Walgreens). If you wish to find a list of additional pharmacies, go on the website, www.EmblemHealth, and click on the appropriate links.

b) Present your GHI card to your selected pharmacy and have them vaccinate you.

c) GHI will cover the cost of the vaccination.

Medicare Members

a) Get the vaccine and shot at a GHI participating pharmacy.

b) Present your GHI card to your selected pharmacy and have them vaccinate you.

c) Although the vaccine is covered by GHI Medicare Enhanced Plan D, you will have a co-pay, the amount depending on what Tier you are in. For example, if you haven't entered the "donut hole," the co-pay will be 25% of the cost of the vaccine or about $50. Check with the pharmacy first to see if it will cover the cost (or part of the cost) of the vaccination. If it does not, you will be responsible for the full cost and there will be no reimbursement.

By the way, shingles is not rare. About a third of all Americans will get shingles in their lifetime. Half of the people who reach 85 will have had shingles at some point.

3. Enhanced Plan Part D

Last month Emblem Health (GHI) Enhanced Plan Part D sent you an Annual Notice of Changes for 2019 booklet. I strongly urge you to read it carefully. The booklet takes you step-by-step on what you should do now. Basically, you want to know what changes, if any, affect you. The changes that are especially important to read about concern GHI's Drug List. Most likely, it will not affect you. However, review it to see that your drugs are still covered or if there will be any restrictions.

If you are taking a drug no longer covered in 2019, you can:

· Ask your doctor to ask the plan to make an exception to cover the drug. This should be done before the start of the next year. If you had an exception in 2018, you must re-apply for 2019. The procedure for applying is in the GHI booklet, Evidence of Coverage. You can also call customer service.

· Have your doctor prescribe a similar drug that the plan covers in 2019.

One change starting in 2019 that can affect you is that the plan can immediately remove a brand name drug on their Drug List providing they substitute it with a generic drug on the same or lower cost-sharing tier. Also, the plan may make other drug changes during the 2019 year, however, they must inform you of these changes 30 days prior to the changes or give you a 30 day refill if it is a brand name drug.

Informational Update Vol. 9 #7

1.New Medicare Card

Have you received your new Medicare card yet? If not, don't worry. Your new card will be coming to you automatically. There is nothing for you to do except make sure your address is up-to-date with your Social Security account; the address your card is mailed to is the one Social Security has for you.

What to do when you receive your new Medicare Card

As soon as you receive your new card, tear up the old one and throw it away. As soon as you go to the doctor, show the receptionist the new card. They need it to get your new ID number.

Protect the Card

When you receive the new card, do not laminate it. Social Security has said the card may have certain security features built into it that could be compromised by the laminator. What I suggest is that you make a copy of the card and your secondary insurance card, put them back to back, and either laminate them or put them in a plastic holder. That is what you should carry with you. It is unnecessary to carry your Medicare card. Put it away in a safe place.

Fighting Medicare Fraud

The main reason for changing the "look" of the new Medicare card is to protect you against Medicare scams and fraud. No longer is the SS number on the new card. Instead, the card will have a unique Medicare Beneficiary Identifier (MBI). This identifier has a unique composite of numbers and letters. The numbers range 0-9. The letters S, L, O, I, B & Z will not be used.

Despite the care Social Security has taken to protect your identity, fraud or scams can still take place. Please be careful not to give any personal information or money over the phone in connection with your new Medicare card. Interestingly, because new cards are being issued, more people are trying to scam you than before the cards were being issued.

2. CSA Welfare Retiree Fund Optical and Hearing Aid Benefits

Recently, I have received several questions about the CSA Welfare Fund optical and hearing aid benefits. Let me clarify.

Ø Optical Benefits – You are entitled to an optical benefit every 12 months. The process involved in using this benefit, which is worth a $100, is the following:

· Obtain an optical voucher. You can get this voucher by either downloading it from the CSA Welfare Fund website, or calling the Fund, 212-962-6061.

· Go an optical store of your choice. No longer are there participating optical centers.

· Sign the bottom of the voucher and return it to the CSA Retiree Fund along with proof of payment and a copy of the itemized bill for your glasses or contact lenses.

Remember, the voucher is only good for 60 days from the time of the request. If it is not used within that period and you still need a voucher, you must return the unused voucher in exchange for a new one.

In addition to the CSA Welfare Retiree Fund benefit, the CSA Retiree Chapter will reimburse you up to $65 (went from $55 to $65 Jan 1, 2018). You do not have to apply for the $65. You will automatically receive it about 2 weeks after you receive your reimbursement from the CSA Retiree Welfare Fund

Hearing Aid Benefits – You are entitled up to an $800 hearing aid benefit every 36 months.

You will need a voucher, which can be obtained and used as described above for the optical voucher, to purchase the hearing aid. If you use a participating hearing aid center, the Fund will pay them up to $800, otherwise they will reimburse you. However, before you can be reimbursed, you will have to submit the signed voucher, proof of payment and an itemized bill.

In addition to the Fund's benefit, the CSA Retiree Chapter will also reimburse you up to $800 every 3 years. Again, you will not have to apply for the reimbursement, it will come to you automatically about 2 weeks after you receive your reimbursement from the Fund.

Informational Update Vol 9#6 August 2018

1. Drug Prices of Refills

When you refill a prescription, the price often differs from when you first paid for the prescription. In fact, the price can vary from refill to refill. Why? There are many possible reasons, including change in manufacturing costs, contracts with network pharmacies, and re-classification of the drug from a Tier 1 drug to a Tier 2 drug. For those on Medicare and enrolled in the GHI enhanced Part D drug plan (most Medicare members) there could be another reason.

Under Medicare Part D, there are 3 coverage periods: initial coverage period, coverage gap (known as "donut hole"), and catastrophic coverage. Within each period you pay a different amount for drugs.

- § Initial Coverage Period – you pay 25%, your plan pays 75%.
- § Coverage Gap – Begins when you and your plan together have paid $3,750 for covered drugs.

Brand Name Drugs

You pay 35%, your plan pays 65%

Generic Drugs

You pay 44%, your plan pays 56%

- § Catastrophic Coverage – Begins when you have paid $5,000 (out-of-pocket) for covered drugs – You pay 5%, plan pays 15%, Medicare pays 80%.

So, if you are on Medicare, your change in cost could be due to your entering a new coverage period. I strongly recommend that if your prescription price changes, ask your pharmacist why.

2. Equipment and Supplies Covered by Medicare

Medicare will cover some equipment known as Durable Medical Equipment (DME) providing it helps you do your daily activities. The equipment will have to:

- · Withstand repeated use
- · Serve a medical purpose
- · Be usable in the home, although you can use it outside of the home, and
- · Last a minimum of 3 years.

To get Medicare coverage for your DME, you will have to get prescription from your doctor. You will also have to purchase the DME from a Medicare supplier. If you are a hospital inpatient or in a skilled nursing facility the DME is covered by Part A.

Examples of DME include:

- Ø Wheelchairs
- Ø Walkers
- Ø Hospital beds
- Ø Power scooters
- Ø Portable Oxygen Equipment
- Ø Orthotics
- Ø Prosthetics

Medicare also covers certain diabetes supplies, such as, lancets and test strips used with diabetes. Further, Medicare covers certain prescriptions and supplies that you use with your DME. For example, Medicare will cover medications used with a nebulizer.

The CSA Retiree Welfare Fund Supplemental Medical Program also covers some DME and supplies, such as, wigs for cancer treatment or alopecia ($1,000 max per year – CSA Retiree Chapter gives additional 20% of cost), orthotics (max equals $400 per pair, 2 pair max for a total of $$800), surgical stockings (3 pair per year

max annual $150 max), and a removable or portable toilet seat (1 per year max $100).

3. Difference Between Deductibles & Co-Pays

Ever been confused by the medical terms, co-pays and deductibles. If so, you may be having trouble understanding how much you need to pay for your health care. Consequently, let's take a look at these terms so that you will better understand what they mean and how they are connected.

Deductibles

A fixed amount that you pay for medical services or drugs (no drug deductible for Medicare before your health plan begins to cover medical services. For example, if you are on Medicare, there is a $183 deductible that starts at the beginning of the year.

Co-Pays

A flat fee or percentage of the cost that you pay every time you go to a doctor (no co-pays for Medicare-eligible members) or have a prescription filled (no drug deductible for Medicare-eligible members). Co-pays kick in after the deductibles are met.

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Informational Update Vol 9 #3 - March 2018

1. Does Medicare Coverage Extend Outside of the USA? – In most cases, Medicare does not cover medical services or health supplies outside of the USA, including using a doctor on a cruise ship. "Outside the USA" means anywhere outside of the 50 states, the District of Columbia, Puerto Rico, the US Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. However, if you incur a medical expense abroad, GHI, as your secondary coverage, will offer coverage. The way it works is:

Ø Blue Shield Blue Cross will cover hospitalization.

Ø Emblem Health (GHI) will cover 100% of the amount it allows (which may not be much) for a medical expense after a $200 deductible.

Ø Procedure for Receiving Reimbursement: You must have an itemized bill in English. The money must be in dollars and cents. Submit the bill along with proof of payment to the CSA Retiree Welfare Fund, 40 Rector St., New York, NY 10006, Attention: Dr. Douglas Hathaway

Because GHI offers minimal coverage in a foreign country, I highly recommend you obtain travel insurance before traveling abroad.

2. "Valentine's Gift" – Retired CSA administrators or supervisors who are Medicare eligible and have the GHI Enhanced Plan D plan should have received their "Valentine's gift" of $480 for 2017 this past February. This is a CSA Welfare Fund benefit designed to help defray the cost of the High Option Rider that pays for the Enhanced Plan D. The amount was sent in a check. Those who were eligible for reimbursement, but were not on Medicare for the full year, should have received a pro-rated check.

Eligible CSA retirees who have not received a check should contact the CSA Retiree Welfare Fund, 212-962-6061. Remember, only Medicare eligible CSA retirees are entitled to the "Valentine's Gift." If both husband and wife are Medicare eligible CSA retirees, then both are entitled to the gift.

For non-Medicare CSA retirees and non-Medicare dependent spouses, the CSA Welfare Fund and CSA Retiree Chapter will continue to cover copays, providing the member and spouse are under the GHI or HMO plans. After a $100 deductible,

the reimbursement is 80% of the drug cost up to a maximum of $10,000. In addition, the CSA Retiree Chapter supplements the reimbursement with an additional 20% of the Fund payment.

3. Medicare Coverage of Immunizations and Vaccines – Medicare covers vaccines and immunizations. How they are covered and the costs will depend on the type of immunization and your particular circumstance.

Most vaccines and immunizations are covered under Medicare Part D prescription drug benefit. If you need to get one of these immunizations, check with the CSA Retiree Welfare Fund to learn the coverage and cost to you.

There are three immunizations that fall under Medicare Part B since they are considered preventative. These immunizations are covered at the 100% Medicare-approved amount. This means that if you receive one of these immunizations from a Medicare doctor, you will not have to pay anything. These immunizations are:

v Flu Shot – Medicare Part B pays for 1 shot per year. In some instances, depending when you received the shot, it may pay for two. For example, if you got one Jan 2018 for the 2017/18 season, you could get another in December 2018 for the 2018/19 season.

v Pneumonia Shot – Part B covers two separate shots. If you are receiving a shot for the first time, Part B covers the first shot. The second year, you will be covered for a different, second vaccination. You are not required to provide any vaccination history. Your word will be good enough.

v Hepatitis B Shot – Part B covers this shot if you are medium to high risk for hepatitis B. You should ask your family doctor if you are in the aforementioned categories. If you are a low risk candidate for hepatitis B, Part D covers the vaccine.

There are other medically necessary vaccines, e.g., rabies shot, covered by Medicare Part B, but only 80% of the cost. However, your secondary coverage should pick up the other 20%.

4. Medicare Therapy Caps Removed – Great News! The Medicare cap of $2010 for Physical, Speech and Occupational Therapy has been removed as a result of Congress repealing the caps. Under the cap, you would only be able to get about 16 sessions. If you were lucky, you were able to get an extension. Now, the cap no longer applies and you can get therapy for as long as your doctor says you need it.

What about the CSA Retiree Welfare Fund Therapy benefit? The Fund is reviewing that benefit to see if it can be applied to another area. More on that in the future.

Informational Update Vol 9 #1 -- January 2018

1. 2018 Medicare Part B Deductible & Premiums – As you start to visit your Medicare doctors in 2018, you will have to pay deductibles again as they reset January 1. The deductibles remain the same: Medicare is $183 and GHI is $50. The amount of the $183 deductible that you pay when you visit a doctor will depend on the doctor's services; most likely it will be less than the full amount. The amount that is left will be paid at a future doctor visit or visits.

This year standard Medicare Part B premium remains at $134, which most of our members pay. However, some people who receive Social Security benefits may be paying less. Why? By law, you cannot increase the Part B premium more than the Social Security cost-of-living annual increase. This year, for the first time in recent years the increase has gone up 2%. As a result, approximately 30% of those who paid $109 in 2017 will get an increase, but only to about $130.

Yes, it all can be very confusing. But there is nothing you have to do to calculate your premium. Social Security does it for you and notifies you by letter, which you should have received in November.

Approximately 5 to 6 percent of those on Medicare earned a large enough income in 2016 (what you pay in 2018 is based on this amount) to pay an extra charge, known as the income-related monthly adjusted amount or IRMAA, on top of the standard amount.

The good news is that both the standard and IRMAA amounts are still reimbursable. More on that in future Informational Updates.

2. High Option Rider – Some of you have questioned me about the monthly $107 deduction on your pension check, under the code GHI-CBP/EMPE. This is the High Option Rider, which pays for the Medicare Part D drug premium in full or part, depending on your taxable annual income. If you have been subject to an IRMAA surcharge in 2018 for Medicare Part B, then you are also paying an

IRMAA surcharge for 2018 Medicare Part D. This amount is deducted from your Social Security check and is in addition to your high option rider that is deducted from your pension check.

3. Pain Management – Acupuncture – I have received several calls about the new Acupuncture benefit that is retroactive to January 1, 2017. To clarify, after a $100 deductible, you get back 80% of the cost up to 18 visits. The acupuncturist MUST be a licensed provider.

When submitting for reimbursement, you must complete a form which you can get by calling the CSA Welfare Fund. The form must contain the acupuncturist's name, address and state number, as well as an itemized description of the service(s) provided and amount charged for each visit. If the acupuncturist is not licensed (or lives in a state which does not license acupuncturists), he or she must provide proof of accreditation by the National Certification Commission for Acupuncture and Oriental medicine (NCCAOM).

Informational Update Vol. 8 #9 - December 2017

1. 2016 Medicare Part B Differential Reimbursement.

Last month, I wrote that eligible Medicare retirees and their dependents received automatically this past June (no application required) the 2016 standard reimbursement for Part B. The amount ($1,256.80) was based on a monthly payment of $104.90. However, not all retirees paid $104.90. If a retiree 1) was enrolled in Part B for the first time, 2) did not collect Social Security, 3) did not have Part B deducted from his or her Social Security check, or 4) paid an IRMAA surcharge, he or she paid the standard amount of $121.80, or a difference $16.90. Consequently, the retiree was still owed $202.90 (Part B differential reimbursement - 12 x $16.90), which would be paid in November.

On November 10 2017, eligible Medicare retirees, who 1) received their 2016 IRMAA reimbursement in October, and 2) have their pensions electronically deposited, received their Part B differential reimbursement. Those retirees who don't use electronic deposit, should (and possibly already have) receive a check shortly.

Please note that retirees who did not receive the 2016 IRMAA reimbursement in October because they did not file an application, should file one now. Once they file the application, they will eventually receive their IRMAA reimbursement as well as the Part B differential reimbursement.

Finally, some retirees paid the $121.80 monthly Part B premium, but did not have to pay an IRMAA surcharge. This group is also entitled to the $202.90 reimbursement, but must apply for it as if they were applying for an IRMAA reimbursement, i.e., submit an IRMAA application along with a copy of the 2016 SSA letter and 2016 SSA-1090 letter.

2. 2018 GHI Standard Enhanced Medicare Prescription Drug Plan (PDP) Part D

If you are on Medicare and covered for drugs by the GHI Standard/ Enhanced Medicare Part D Prescription Drug Plan (PDP), you should have received your Emblem Health book, Evidence of Coverage, for 2018. This book contains your benefits and services under this plan. I strongly suggest you read it and pay special attention to the insert, Annual Notice of Change for 2018.

Changes to Formulary or Drug List

Because GHI has made changes in its formulary for 2018, it is important that you check to see that your drugs are still on the list. You can get a full listing by calling Customer Service or visiting the website, www.emblemhealth,com/medicare.

If a drug is not on the list or is restricted, you can:

Ø Have your doctor write a letter, asking the plan to make an exception and cover the drug. You should have your doctor ask for the exception before the start of 2018. If you or your doctor is not familiar with the procedure for asking for an exception, you can call Customer Service, or:

Ø Have your doctor prescribe an alternate drug that is on the 2018 formulary.

If you have received a drug exception in 2017 and plan to continue taking the drug in 2018, you must again ask for an exception.

Sometimes the plan is required to cover a non-formulary drug one time only for the first 90 days of the plan year. To learn more about this call Customer Service.

3. 2018 Social Security Administration (SSA) Letter

If you are on Medicare, you should have received your 2018 SSA letter, indicating your monthly benefit amount before deductions, 2018 monthly premium (standard + IRMAA), Part D IRMAA, and your 2018 monthly benefit amount minus deductions. Before you go any further, put this document in a safe place. If you are eligible, you will need the SSA when you apply for 2018 IRMAA reimbursement. You will be notified sometime in 2019 when you can apply.

The letter also lists your Medicare Part B and Part D (if eligible) premiums. In many cases, there was no change in the standard Medicare deduction of $134. However, if your standard Medicare deduction was $109, more than likely it went up to $134. The reason for this is that in 2016 and 2017, you were held harmless, i.e., the increase in Social Security for those years was insufficient and was less than the increase in the Medicare standard deduction of $134. However, that changed for 2018.

In 2018, the increase in Social Security is large enough so that the hold harmless provision does not apply for a large percentage of those enrolled in Medicare Part B. Those affected will now pay $134. However, it is estimated that only about 28% will continue to pay less than $134 because the Security benefit is not large enough to cover the full Part B standard amount of $134.

Informational Update Vol. 8 #8

Hi everyone! Hope all is well. Here is some important information:

1. 2016 IRMAA Reimbursement. If you were eligible for 2016 IRMAA, have your pension checks electronically deposited to a bank account, and the Office of Labor Relations received your IRMAA application by September 27, your 2016 IRMAA reimbursement was electronically deposited to that account on October 13. If you receive a pension check monthly, then the pension check was mailed to you.

Previously, you received the standard reimbursement in June 2017. However, the reimbursement was based on a payment of $104.90 per month, despite the fact many of the members paid $121.80, or a difference of $16.90. In short, these members are still owed 12x$16.90 or $202.90 for a full year (pro-rated if you were on Medicare in 2016 for a portion of the year). You should receive the difference in November in the same way as you did IRMAA.

2. New to Medicare. If you are turning 65, have no employer-based coverage (some members may still be working) and are on Social Security, you will automatically be enrolled in Medicare parts A & B. You should, however, send a copy of your Medicare card (make sure to sign the card) to the CSA Retiree Welfare Fund who will alert the Office of Labor Relations (OLR). OLR will notify your city health plan of the change in your medical status. Once you are on Medicare, that becomes your primary coverage (pays for about 80% of the cost) while your health plan becomes your supplement (pays for about 20% of the cost). If GHI is your supplement, you will automatically be enrolled in the Enhanced GHI Plan D (assuming you have the high option rider), which is your drug plan. While there is a premium for Part B, there is none for Part A and Part D, although you may have to pay a surcharge for Part D (Part B also), if your taxable income is greater than a certain amount.

If you are turning 65, but are not on Social Security and have no employer-based coverage, you will need to enroll in Medicare Part B to avoid any penalties. You should also enroll in Part A (hospitalization) as well (there is no cost). You can enroll for Parts A & B in one of three different ways:

· Online at www.SocialSecurity.gov.

· By calling Social Security at 1-800-772-1213 (TTY users 1-800-0778), Monday through Friday, from 7AM to 7PM.

· In-person at your local Social Security office.

You should also inform your city health plan, which now becomes your supplement, of your change in medical status. If your supplement is GHI, you can enroll in the Enhanced GHI Plan D, which is covered by the city.

Social Security will bill you for Medicare Part B and any Part D surcharge.

3. Home Health Aide Care – Unfortunately, too many members are unfamiliar with our wonderful CSA Welfare Fund and CSA Retiree Chapter benefits. In subsequent Updates, I will review all of them and, if applicable, their relationship with Medicare. I will start by reviewing the one that I am most frequently asked about: the home health aide care coverage.

When you or your spouse/significant other come home from a hospital, you may be in need of temporary home health care to provide personal services, such as, bathing, using the toilet, and dressing. A home health aide, which can be obtained from a home care agency, provides those services.

Coverage for a home health aide is as follows: After an annual $100 deductible, you will get back 80% of the cost up to a max of $8,000 annually with a lifetime max of $24,000. As an added benefit, the CSA Retiree Chapter will reimburse an additional 15% of whatever the Fund reimburses you.

For example, if you receive a home health aide bill of $350, you will get back after the annual $100 deductible, 80% of $250 or $200 plus an additional 15% of $200 or $30 for a total of $230.

What you need to apply for reimbursement

1. A completed application. The application can be obtained from the CSA Retiree Welfare Fund.

2. A doctor's prescription establishing the need.

3. A log of the hours of service. Be certain the aide is certified.

4. Proof of payment. Pay by credit card or check.

Keep in mind that you can spread out the use of the $24,000 over more than 3 years since if you do not reach the max in a given year, the remainder rolls over.

New Medicare Cards – This article appeared in LHV Unit Newsletter. Special thanks to Janice Imundi and the LHV Unit,

One of the major problems with the current Medicare card is that the ID number is the same as your Social Security number. Since you have to carry this card with you, there is a chance you might lose it or have it stolen, thus increasing the chance of identity theft.

The good news is that the Federal government is in the process of issuing new Medicare cards without your Social Security number. Instead, the card will be identified by 11 randomly generated characters. This new system is being designed to protect your Identity.

Because there are 53 million people on Medicare, the implementation of issuing new cards is huge and will be done over a period of time. The Centers for Medicare and Medicaid Service will begin sending new cards in April 2018. It is anticipated the completion of this task will take until December 2019.

Sometime in 2018 you will receive information on the new Medicare card and how to use it. You also will be told what to do with your old card. Once you receive your new card, you can begin to use it.

Until you receive your new Medicare card, I urge you to protect your old one from being taken or lost. Here are some things you can do in that regard:

• Make a copy, cut it down to wallet size, and black out with a black marker the digits of your SSN. You can carry that with you instead of your official Medicare card, unless you see a new provider who needs to make a copy of your original card.

• If your card is lost or stolen, replace it by calling the Social Security Administration (SSA) at 1-800-772-1213 or by contacting your local SSA office.

• Watch for Medicare fraud. Examine your quarterly Medicare summary notice to see that you received all of the services or supplies listed. If you find that the list contains items you did not receive, call the Inspector General's fraud hotline at 1- 800-447-8477. Also, if someone uses your SSN to obtain credit, loans, telephone accounts or other goods and services, report it immediately to the Federal Trade Commission at 1-877-438- 4338.

A Note from Don Mattson: BEWARE OF POSSIBLE SCAMS! You will not receive a phone call requesting information for your new card. THIS IS A SCAM! Do not give anybody your present Medicare number or any checking account information. If you should receive a phone call from CMS claiming they need to know your participation number, hang up. THIS IS A SCAM! CMS would already have your participation number.

Informational Update Vol. 8 #5 - Addendum June 2017

Just for members who were on Medicare in 2016

Medicare Part B Standard Reimbursement – Some members have called expressing some confusion about their 2016 Medicare Part B standard reimbursement, which OLR sent out earlier in the month. After speaking to Doug Hathaway, CSA Welfare Fund Administrator, let me try to clarify.

First, if you (and your dependent, if any) went on Medicare in 2015 or earlier, your "standard" Part B premium was $104.90, and you (and your dependent) should have received $1258.80.

Second, if you (and your dependent) went on Medicare in 2016, your "standard" Part B premium was $121.80. If you (and your dependent) were on for the whole year (pro-rated if less than a year), you (and your dependent) should have received $1461.60. Unfortunately, you (and your dependent) received the same $1258.80. The good news is you will be reimbursed the difference of $202.80 ($1461.60 - $1258.80). Here's how:

- **For those who were eligible and applied for 2016 IRMAA, you will be reimbursed automatically in October along with IRMAA.**

- **If you are not eligible for IRMAA, THE REIMBURSEMENT IS NOT AUTOMATIC; you must document that you paid the $121.80 standard amount. How do you document it? Make copies of the SSA letter you received in November 2015 informing you of your 2016 Part B premium and the SSA-1099 letter you received in January 2017 indicating the total amount you paid in 2016, and send them to the CSA Welfare Fund, 40 Rector St., 12th floor, New York, NY 10006. The Fund will make sure you sent the appropriate documents and will walk them over to the Office of Labor Relations.**

Informational Update Vol. 8 #5

1. <u>Medicare Part B Reimbursements</u>. You should have received an email from the CSA Retiree Chapter informing you that from now on, the Office of Labor will be issuing both the Medicare Part B standard and the IRMAA reimbursements within the same calendar year: the standard reimbursement in June and the Income-Related Monthly Adjustment (IRMAA) in October. Consequently, according to the Office of Labor Relations (OLR), the 2016 Part B standard amount will be reimbursed this month (the checks started coming in today) while 2016 IRMAA will be reimbursed in October 2017. Remember, everyone who was on 2016 Medicare is eligible for the standard reimbursement. This reimbursement will come automatically; you do NOT have to apply. However, only those who paid 2016 IRMAA are eligible for the 2016 IRMAA reimbursement. This reimbursement will not come automatically; you must apply for it. If you have not yet filed for your 2016 IRMAA reimbursement, you can still do so by either 1) sending the

appropriate documents (SSA letter for 2016 and SSA-1099 for 2016) to the CSA Welfare Fund, or 2) sending a completed application (2016 application can be downloaded from the CSA Welfare Fund website, www.csawf.org) along with the appropriate documents to OLR. If you have not filed for IRMAA in previous years and were eligible for reimbursement, you can still do so now. The applications for 2014 & 2015 can also be downloaded from the website.

As I wrote last month, The CSA Retiree Chapter periodically emails updates to the members. If you have not been receiving them, please make sure your current email address is on file with the CSA Retiree Chapter. Also, make sure the restrictions on your email do not place the chapter's emails (or mine, for that matter) in your spam file.

2. Home Helper Benefit. I do not need an aide for personal or medical care. Rather, I need a home helper to assist me with some simple household chores, such as, housekeeping, running errands, meal preparation and driving me to the doctor. Is that covered by the home health aide benefit? According to the CSA Welfare Fund it is covered, providing the helper comes from a licensed home care agency and you have a doctor's prescription.

The benefit is the same as for a home health aide. After $100 annual deductible, you are reimbursed 80% of the cost up to a maximum of $8,000 annually, lifetime limit of $24,000. The CSA Retiree Chapter will also reimburse you 15% of the Fund's payment. Keep in mind that you may choose not to reach the $8,000 limit in a given year. In that case, what remains rolls over to the following year.

When you seek reimbursement for the helper, you will have to complete a Home Health Aide form. You may download the form from the Fund's website, www.CSAwf,org. You do not have to apply for the additional 15% as you will receive it automatically in a separate check after you receive the Fund's payment.

3. Wellness Visit. If you are on Medicare for more than 12 months, you are entitled to what is known as a "Wellness" visit free of charge. This visit is an annual benefit and takes place at your family doctor.

The wellness visit is not your normal full body health exam. It is intended to develop, or update if this isn't your first wellness visit, a personalized health plan based on your current health status. You should take advantage of this benefit as it can help lower your health risks.

What is done at a wellness visit? According to the official Medicare website, it lists the following:

- **Health risk assessment. (Your doctor or health professional will ask you to answer some questions before or during your visit, which is called a health risk assessment. Your responses to the questions will help you and your health professional get the most from your yearly "Wellness" visit.)**
- **Review of medical and family history.**
- **Develop or update a list of current providers and prescriptions.**
- **Height, weight, blood pressure, and other routine measurements.**
- **Detection of any cognitive impairment.**
- **Personalized health advice.**
- **A list of risk factors and treatment options for you.**
- **A screening schedule (like a checklist) for appropriate preventive services**
- **To get the most out of your wellness visit, you should bring a complete list of your medications (both prescription and non-prescription) along with a list of all your doctors. Also, bring a list of questions you wish to discuss with your doctor.**

May 9, 2017 Updates from Norm Sherman

2015 IRMAA Reimbursement.

Some of you have called asking about an IRMAA reimbursement you had received last month. To be clear, the CSA Retiree Chapter (not the local unit) emailed an update in early April indicating that the 2015 IRMAA reimbursement for those members with direct deposit would come around mid-April (change from this coming June). Because of the heavy flow, some

received it toward the end of the month. OLR will be mailing out the reimbursement checks for those who are not on direct deposit.

Some also questioned the amount they received; they felt it was too small. In questioning them, I realized they were looking at the wrong document to determine how much the reimbursement should be. If you want to check whether the reimbursement is correct, look at your Nov'14 SSA letter (hopefully you still have it). This letter shows the monthly IRMAA you paid in 2015. Multiply that amount by 12 unless you were on Medicare for only part of the 2015 year. In that instance, multiply by the number of months you were on Medicare. (For example, if you went on Medicare in November 2015, multiply the amount by 2.) The total that you get should equal the amount of the reimbursement. If it does not, feel free to contact me.

The CSA Retiree Chapter periodically emails updates to the members. If you have not been receiving them, like the one I mentioned above, please make sure your current email address is on file with the retiree chapter. Also, make sure the restrictions on your email do not place the chapter's emails (or mine, for that matter) in your spam file.

2. Coming: Improved CSA Retiree Welfare Fund Benefits. The CSA Retiree Welfare Fund will be announcing new improved benefits retroactive to January 1, 2017. These benefits cover two important areas:

· Dental. There will be additional coverage for several procedures, including bridges, crowns, root canals, exams and cleanings.

· Pain Management - Acupuncture. This will please many members who had previously asked whether this procedure was covered. After a $100 deductible, you get back 80% of the cost up to 18 visits. The acupuncturist MUST be a licensed provider.

The CSA Retiree Fund will send you a letter shortly, informing you of the details. Please be on the lookout for it.

3. Physical Therapy Coverage. Q. You, as a Medicare patient, were discharged from a hospital after having shoulder replacement surgery, and require physical therapy. What coverage do you have? A. In 2017, as an outpatient, Medicare will cover up to $1,980 after you have paid your $183 deductible. Medicare will pay up to 80% of the approved amount while your secondary will pay the rest (for most members that is GHI). In general, depending on the cost, you will be entitled to 20 – 22 sessions.

If your therapy is approaching the cap, but your doctor feels you can benefit from additional therapy, he or she can inform Medicare that it is medically necessary for you to continue. Hopefully, Medicare will approve. However, if it does not, you can utilize the CSA Retiree Welfare Fund's physical therapy benefit.

After a $100 annual deductible, the Fund will reimburse you up to $2000 for physical therapy after you have used up your primary (Medicare) coverage. When requesting reimbursement, you should submit:

1) **A prescription from the doctor**
2) **Proof you have exhausted your Medicare coverage**
3) **Copy of the bill and proof of payment.**

Informational Update Vol 8 #3

1. **Problem Contacting the CSA Retiree Welfare Fund** - I have received many calls about not being able to contact the CSA Retiree Welfare Fund. On April

7 you should have received a Member Update from Doug Hathaway, Fund Administrator, mentioning the severe problems the Fund was having with phone service. Full service was expected back at the earliest on April 18. It is suggested that when you call the main voice number, 212-962-6061, leave a message. It is also recommended that you call Doug's cell phone, 646-629-3955 and, if necessary, leave a message. Doug has indicated all calls will be returned.

2. Valentine's Gift – In February, around Valentine's Day, all Medicare eligible members under the GHI Enhanced Plan D should have received their "Valentine's gift" of $480 for 2016. If you were not on Medicare for the full 2016, your check should have been pro-rated. Those eligible members who still have not received a check should notify the CSA Retiree Welfare Fund, 212-962-6061. Please note spouses of Medicare eligible members, whether they are on Medicare or not, are NOT eligible to receive a check.

For non-Medicare retiree members (and their dependents) who are under the GHI or HMO plans, the CSA Retiree Welfare Fund will reimburse their drug co-pays. After a $100 deductible, the reimbursement is 80% of the drug cost up to a maximum of $5,000. In addition, the CSA Retiree Chapter supplements the reimbursement with an additional 15% of the Fund payment.

3. Medicare Summary Notice – If you are on Medicare, you will receive a Medicare Summary Notice each time you used a Medicare doctor or were in the hospital. This document lists your claims and costs for a given period. It is NOT a bill, although it will inform you how much you may be billed, the providers involved, and whether Medicare approved your claims. The document also mentions how to report a fraud and how to file an appeal for a denied claim.

Because it is the right thing to do, you should report any claims that appear fraudulent. But what you may not realize, a fraudulent claim can have a negative impact on your coverage. For example, you review a Medicare Summary Notice and see a claim from a physical therapist for $600. However, you report this claim as fraudulent since you never received the therapy on the date mentioned. If you had not reported it, then your $1980 of Medicare coverage for physical therapy

would have been reduced by $600. Motto? Review the Medicare Summary Notices carefully

4. Are You a Hospital Inpatient or Outpatient? – If you are on Medicare it is important that you ask. Your hospital status, i.e., whether you are an "inpatient" or an "outpatient," affects how much you are going to pay for hospital services, such as, X-rays, drugs, and lab tests and may also affect whether you can get into a skilled nursing facility (SNF) after your hospital stay.

· Inpatient Status – begins when you are formally admitted to the hospital with a doctor's order. You are covered by Medicare Part A which pays for all your hospital services for the first 60 days. CSA members and their dependents who have the high option rider are covered for 365 days.

· Outpatient Status – occurs if you're getting emergency department services. Medicare Part B will cover about 80% of most of the doctor services after you pay the annual Part B deductible of $183. If you have secondary coverage, like GHI, it will pick up the other 20%. In the case of GHI there is a $50 annual deductible. Part B generally does not cover prescribed or over-the-counter drugs. More than likely, even if you have a Part D plan (most members have the GHI Enhanced Plan) you will have to pay for the cost of the drugs. You can then file a claim with your drug insurer.

It is important you understand that if you are an outpatient and told you need to stay overnight in the hospital for observation, you will be staying as an outpatient unless a doctor admits you into the hospital. Remaining as an outpatient will most likely be more costly. Consequently, make every effort to have a doctor admit you before staying overnight. The coverage is much greater.

2015 SSA-1099-Social Security Benefit Statement

By now, you should have received your SSA-1099 letter for 2016. This form letter shows the net amount of Social Security you received for 2016, the total

deductions for Medicare Part B and Part D taken from your 2016 Social Security, and your final 2016 Social Security Benefit. The Part B deduction includes the standard amount + the IRMAA surcharge (if eligible – taxable income must be more than $85,000 as an individual or $170,000 as a couple). The good news is the Part B deduction is reimbursable; the standard amount should come automatically in June 2017 and the IRMAA surcharge in June 2018. The IRMAA reimbursement is not automatic; you must apply for it.

Although you can apply on your own for 2016 IRMAA – application will be available when you receive your 2016 standard reimbursement in June – you can take advantage of CSA Welfare Administrator Doug Hathaway's offer made at both the recently held Southeast Florida and Suncoast Unit meetings. Doug said that if you send him both the SSA-1099 letter and the SSA letter for 2016 (you received the SSA letter in November 2016) he will process your 2016 IRMAA application when it becomes available. This is an offer you should not refuse as you will not have to do anything else to collect the 2016 IRMAA reimbursement. Also, it will reduce the chance of losing these important documents.

IF YOU SEND IN THE DOCUMENTS TO DOUG HATHAWAY, KEEP A COPY OF THEM. IF YOU ARE NOT ELIGIBLE FOR 2016 IRMAA YOU DO NOT HAVE TO DO ANYTHING. JUST FILE THE DOCUMENTS IN A SAFE PLACE.

Medicare Part D Costs - Changes for 2017

Most Medicare eligible members are in the GHI enhanced Medicare Part D drug plan. This plan has 3 Tiers, with the cost of prescription drugs varying according to which Tier you are in. If you noticed a change in your prescription costs it may be due to the fact that on January 1, 2017, you started all over again, i.e., you went back into Tier 1. In this Tier, the plan pays 75% of the drug cost; participant pays 25% (same as last year). Unfortunately, some will enter Tier 2, known as the Coverage Gap or "Donut Hole" at some point during 2017. This will occur if your total drug cost in Tier 1 exceeds $3,700 (up from $3,300 in 2016). This total includes what you pay ($925 – known as Troop and up from $827.50) plus what the plan pays (80% of the cost). Once you are in the coverage gap, the plan pays 49% (participant 51%) of the generic drug cost and 60% (participant 40%) of the brand name drug cost. This is much better than last year when the plan paid much less of both the generic and brand name drug costs. If your Troop goes over $4,950

(an additional $4,025 – what the plan pays does not count towards the Troop) you enter Tier III or the Catastrophic Coverage. In Tier III the plan pays 15%, Medicare pays 80%, and participant pays only 5% of the drug cost.

As an additional benefit in Tier III, you can get reimbursed for your 5% cost up to $5,000. Just submit your monthly statements to the CSA Welfare Fund for reimbursement. I suggest you submit these bills at the end of the calendar year to make the CSA Retiree Fund's processing of your request easier to handle.

Turning 65

You are a retired member and are soon to turn 65, Medicare age. You ask yourself, is there something I must do to enroll in Medicare? The answer is very little.

About 3 months before your 65th birthday, Social Security will send you an informational letter and Medicare card. If you do not receive this letter, call the Social Security Administration (1-800-772-1213) or visit your local SSA office. If you are not on Social Security, you will have to apply for Medicare. You can do this by calling Social Security or visiting the local SSA office. You can also apply online at www.SocialSecurity.gov.

Send a copy of the card to the CSA Retiree Welfare Fund. The Fund will make sure the appropriate offices are notified.

You will go on Medicare the month you turn 65. The first time you go to a doctor after you go on Medicare, notify the office of the changes in your medical coverage. You will automatically be enrolled in Medicare Part B. Medicare Part B will cover about 80% of your doctor's cost with your secondary (for most members

it is GHI) picking up the 20%. Some medical tests may not be covered as well as the deductibles.

If you have other health care coverage, perhaps through your spouse or significant other, you may delay signing up Part B. If the spouse's coverage ends, you will then have a short period to sign up for Part B without being penalized.

If you want further information, call the CSA Welfare Fund for the guide, Turning 65.

Social Security Letter – In November, you should have received a letter from Social Security (known as the SSA letter) indicating your 2017 Social Security benefit amount before and after deductions. Factors that played a role in this amount included 1) a .3 percent increase before deductions because of a rise in the cost of living, 2) an increase in the deductions for the standard amount and income-related monthly adjustment amount (IRMAA) for Medicare Part B, and 3) an increase in the deductions for Medicare Part D IRMAA.

Please note the first page of the letter contains 4 bullets. The first one shows how much your SS benefit for 2017 is before deductions. The second shows the 2017 deductions for Medicare Part B for the standard amount and for IRMAA, if any. If you have an IRMAA deduction (which would be listed right under the standard amount deduction), then you ARE eligible for 2017 IRMAA reimbursement. However, you do NOT apply for it now. You must wait until you receive your 2017 standard amount reimbursement (will receive automatically) in June 2018 when the 2017 IRMAA application will be first available.

The 3rd bullet contains the 2017 deduction for Part D IRMAA. If you have an IRMAA deduction for Part B then you will for Part D as well. Please note that Part D IRMAA is NOT reimbursable.

It is imperative that you file your 2017 SSA letter in a safe place. You will need to include it in your application package when you file for 2017 Part B IRMAA in June 2018.

Outpatient vs Inpatient Status – Did you know you can be in a hospital overnight for observation, but still be considered an "outpatient?" Whether you are assigned outpatient or inpatient status depends on your medical condition.

More than likely, you will be formally admitted as an inpatient if you are sick enough to warrant skilled, technical care. You can only be formally admitted by doctor's orders. If doctors aren't sure how sick you are or what care you need, but you are too sick to go to a doctor's office, then you may be assigned "outpatient" or "observation" status. It's conceivable that this status remains even if you are in a hospital for more than one night for various testing and observation.

Why Does Your Status Matter?

When you are in the hospital under "observation" status, you are covered under Medicare Part B (medical insurance); Observation status is considered outpatient care.

Inpatient care is covered under Medicare Part A (hospital insurance). Under the High Option Rider you would have full coverage for an extend period of 360 days.

Conclusion

If you are going to be placed in the hospital from an ER, you cannot assume you have "inpatient" status (which would be better than "outpatient" because it might be less costly) unless your doctor makes the recommendation and you have been formally admitted. If you are placed under "observation" status, you should find out from the doctor about the cost of your care.

Payment of Medicare Part B Premium – All of the Medicare members I have dealt with have their Part B premium electronically deducted from their Social Security Check. However, if you are not collecting Social Security (you may be waiting until you are old enough to receive full payment) you will receive a bill called "Notice of Medicare Premium Payment Due" (CMS-500). You can pay this

bill by 1) using your bank's online bill payment service, 2) signing up for Medicare Easy Pay, a free service that automatically deducts the premium payments from your savings or checking account each month, or 3) paying by check, money order or credit card. Check or money order is sent to:

Medicare Premium Collection Center

P.O. Box 790355

St. Louis, MO 63179-0355

If you use a credit card you will have to complete the bottom portion of the Medicare bill, sign it and send it to the above address.

Health Benefits Program – If you are on Medicare, you have been bombarded by mail from various Medicare supplement programs, encouraging you to switch into their health plans. You also have received, or will receive, a letter from the Office of Labor Relations (OLR), explaining that you may now transfer out of your current health plan. This letter affects both Medicare and non-Medicare retirees.

Needless to say, all this activity has generated a barrage of calls and questions. "Why all this mail now?" "Should I switch my current plan?" Good questions causing confusion and uncertainty, which I will attempt to address.

You are receiving all this mail now because retiree private health plans and Medicare plans are now in the transfer period. During this period, non-Medicare and Medicare retirees may switch plans.

· **Non-Medicare Retirees** – The Fall 2016 retiree transfer period runs from November 1, 2016 through November 30, 2016. Changes requested during this period start January 1, 2017. During this period you may add or drop the optional rider. The list of health plans under OLR's Health Benefit Program is found on the front page of the above-mentioned OLR letter.

· **Medicare Retirees** – The transfer period is the same as for Non-Medicare Retirees. Changes requested during this period start January 1, 2017. During this period you may add or drop the optional rider. The list of health plans under OLR's Health Benefit Program is found on the second page of the above-mentioned OLR letter.

The health plans you have received in the mail can be very deceiving. Perhaps, the one that really caught your attention was from Aetna. This plan does a line-by-line comparison with GHI/EBCBS Senior Care Plan (what most have) along with "Original Medicare." On first blush, it looks like a much better plan than GHI as many of the costs are $0. However, understand that Aetna is a Medicare Advantage PPO Plan (all of the others you have received are either in the same category or are HMO's), i.e. a health insurance program of managed health care that serves as a substitute for "Original Medicare" Parts A and B Medicare benefits. Under a PPO, you can go to doctors in or out of the network (HMO you must stay within the network). But if you go out of the network (and your current doctors may fall in that category) the co-pays can get to be quite expensive.

So, where does that leave you, stay or transfer plans? That is a choice you must make. To help you make that decision, I have discussed the matter with the CSA Retiree Welfare Fund, which has recommended NOT transferring to an Advantage Plan. The belief is if you do, your medical costs will be more and you may not be able to use the doctors of your choice.

Must I do anything with the OLR letter if I choose NOT to transfer? NO. You may discard or keep the OLR letter for reference.

2015 IRMAA – As I have said previously, you may now apply for 2015 IRMAA. You can download the application from the CSA Welfare Fund website, www.CSAwf.org. While the application is simple to fill out, you must enclose with it 2 documents: A copy of your and/or your eligible dependent's Social Security Administration (SSA) letter issued to you and/or your eligible dependent at the end of CALENDAR YEAR 2014 showing what the income-related monthly adjustment amount will be in CALENDAR YEAR 2015 & a copy of your and/or your eligible dependent's Form SSA-1099 issued to you by the SSA in January of CALENDAR YEAR 2016, as proof of the monthly Medicare Part B premium actually paid for CALENDAR YEAR 2015. If you cannot provide a Form SSA-1099 because you did not receive Social Security benefits in 2015 you must provide official documentation that you paid Medicare premiums in 2015 (a receipt from Social Security, cancelled checks for Medicare premium payment, or similar official documentation). REMEMBER YOU MUST INCLUDE THE RETIREE'S NAME AND FULL SOCIAL SECURITY NUMBER ON ANY ELIGIBLE DEPENDENT'S DOCUMENTS.

Be sure to save copies of the application and the enclosed documents, and send them return-receipt requested.

Medicare Fraud – Below is a list of ways you can help prevent Medicare fraud.

- Guard your Medicare Card – Do not give out your Medicare number to anyone other than your doctor or other authorized Medicare provider.
- Beware Bogus Medicare Plans – During the Open Enrollment period criminals may try to entice you to join a bogus plan. You can check to see if a plan is bogus by checking the Plan Finder at Medicare.gov. If the plan is not there, then it is not legitimate.
- Do Not Take Fake Health Care Freebies – Just walk away if someone wants your Medicare information in exchange for free medical services and products. Most likely it is a scam to get your Medicare number.
- Review Your Medicare Statements – Medicare will send you periodic Medicare Statements outlining the medical treatment you have received. Review them carefully for accuracy and completeness. Report anything that you think might be in error.

If you suspect fraud, call the Medicare helpline (1-800-MEDICARE or 1-800-633-4227. The helpline is open 24/7.

1. Enhanced Benefits – Recently, the CSA Welfare Fund notified you of the enhancement of two of their benefits.

 Home Health Aide –

In the November CSA News, Doug Hathaway explains what I consider one the most necessary, but underused, CSA benefits: the Home Health Aide. This benefit was revised in 2015 and, after a $100 annual deductible, covers 80% of any additional home health aide expense up to $8,000 annually, $24,000 lifetime. In addition, the CSA Retiree Chapter will reimburse you an additional 15% of the amount you receive from the Welfare Fund.

This benefit can be spread over many years if you decide to use less than the $8,000 in a given year. Whatever is left will be rolled over to the lifetime maximum. For example, if you use only $4,000 in a given year, the other $4,000 will be rolled over, leaving you with $20,000 lifetime.

This benefit can be used in a hospital or rehab center as well as the home. Just remember:

Ø You must have a doctor's prescription showing the need for the aide.

Ø You must use a certified aide.

You should also keep a log of when the aide comes and goes, and pay only by credit card or check.

To collect the benefit, just send a copy of the bill, proof of payment to the CSA Welfare Fund.

 Physical Therapy Benefit – Previously, the benefit was for 20 visits per year. But, Medicare's dollar reimbursement was always able to pick up the 20 visits and, as a result, the Welfare Fund benefit became moot for Medicare retirees. Now, the enhanced benefit is $2,000 plus an additional $300 or ($2,000 x 15%) from the Retiree Chapter. In short, Medicare Retirees are now covered for 20 visits per year through Medicare plus the additional visits (approximately, another 20) using the enhanced benefit. Non-Medicare retirees will be covered for the $2300 or approximately 20 visits.

2. Outpatient Mental Health Services Coverage – In the past two years Medicare began to cover outpatient mental health services to help beneficiaries with depression and other needs.

Once you have met your $147 Part B deductible, original Medicare Part B will pay 80% of the cost of certain outpatient counseling and therapy services such as group therapy and family counseling. Part B also covers services for treatment of beneficiaries who struggle with inappropriate alcohol and drug use. GHI or whatever secondary you have should pay for the other 20%.
Medicare will also cover getting treatment through a variety of mental health professionals such as psychiatrists, psychologists, clinical social workers and clinical nurse specialists. However, keep in mind if you decide to see a non-medical doctor (such as a psychologist or a clinical social worker), you'll need to make sure that he or she is Medicare-certified and takes Medicare & GHI assignment.

3. Drug Reimbursements - I have received several calls concerning Doug Hathaway's Welfare Fund Primer article in the May issue of the CSA News. In it he writes that if a retired DOE participates in a GHI drug plan (which most of you do) then you are entitled to a drug reimbursement as follows: After you pay a $100 deductible, the Welfare Fund reimburses co-payments at 80 percent, to a maximum of $5,000. Unfortunately, this is only true for **NON-MEDICARE RETIREES.** So if you are on Medicare, please do not send the CSA Welfare Fund your quarterly Express Scripts reports looking for a refund. It's not going to happen. However, those on Medicare do receive the Fund's drug benefit of $480. This is what Doug has humorously referred to as the Fund's Valentine Gift since the reimbursement comes around Valentine's Day. In addition, if your out-of-pocket-expenses are large enough to move you out of the "donut hole," the Fund will reimburse you up to $5,000 of drug co-pays at 100% with no deductible. Further, the Retiree Chapter will reimburse you an additional 15% of the Fund reimbursement.

4. Skilled Nursing Facility

Often, individuals confuse nursing homes with a skilled nursing facility (SNF) because of the similarities. In fact, many times the terms are used interchangeably. To be clear, a SNF provides more "skilled" medical expertise and services than a nursing home. Basically, a SNF provides rehabilitation services to help injured, sick or disabled individuals get back on their feet.
Generally, hospitals make the arrangements to transfer a patient to a SNF after an acute hospital stay, such as surgery. The transfer occurs when the patient is released from the hospital. In the SNF, the patient will receive whatever rehab he or she needs like physical or speech therapy until he or she is ready to go home.
Medicare will cover a skilled nursing facility providing you meet the following conditions:

- You need skilled nursing care seven days a week or skilled therapy services at least 5 days a week.

 You were formally admitted to a hospital as an inpatient for at least 3 consecutive days and you enter a Medicare-certified a SNF within 39 days after leaving the hospital.
 You need care that can only be provided in a SNF

What is the coverage for staying at an SNF?

§ Days 21-100: $0. (covered by Blue Cross Blue Shield)
§ Days 101 and beyond: You pay all costs
Remember, being admitted to an emergency room to receive ER services or be under observation does not count toward meeting the 3 day prior hospital requirement for meeting SNF coverage.

5. Hospital Deductible - If you are on admitted to a hospital there will be a $300 deductible. However, under the CSA Retiree Welfare Fund's Supplemental Medical Program, you will be refunded after an annual $100 deductible, 80% of the hospital cost. If this is your 1st use of this benefit for the year, the Fund will refund you 80% of $200 or $160. If you are admitted again to the hospital during a different benefit period (you are out of the hospital for 60 consecutive days), your deductible will again be $300. However, this time you will be refunded 80% of $300 or $240. The max you can be refunded in a year is $750. To obtain a refund, you must submit your bill and proof of payment to the CSA Retiree Welfare Fund.

6. Social Security Letter

By now, you should have received the Social Security letter which shows how much Social Security you will get in 2016. Because there is no Cola increase, this benefit remains the same. Also, the letter lists your monthly Medicare Part B premium, which is deducted from your Social Security check, for 2016. The amount is broken down into two parts:
§ $104.90 or $121.80 for the standard Medicare premium, plus
 The additional premium or surcharge ($0 if you not eligible) for the income-related monthly adjustment amount (IRMAA) based on your 2014 income tax return.

If there is an amount listed for IRMAA, you also will have to pay for a prescription surcharge under Medicare Part D. The letter will show the amount.
The good news is that the yearly Medicare Part B total standard amount and IRMAA for 2016 are both reimbursable; you should receive the 2016 standard amount automatically sometime in August 2017 and should, at that time, apply (if applicable) for the IRMAA reimbursement. There is no reimbursement for the drug surcharge.
Please be certain to file this letter in a safe place. You will need to include it with your application for 2016 IRMAA. In January, you will receive another letter form Social Security that will indicate the yearly Medicare Part B premium you paid in 2015. You will also need to include this letter as well.

7. Medicare -

How do the costs for 2016 Medicare Part B compare to those for 2015?

As you know, you pay a monthly premium for Medicare Part B. The cost is taken out of your Social Security check unless you do not receive Social Security. In that case, you will get a "Notice of Medicare Premium Due" and pay by check or through your bank's online bill payment service.

2015

In 2015, the standard payment for Part B was $104.90. However, if your income reported on your 2013 IRS tax return exceeds a certain amount, you paid a surcharge called Income-Related Monthly Adjustment Amount (IRMAA). The amount of the surcharge will depend on how large your income was. The good news is that the Office of Labor Relations reimburses both the standard amount and IRMAA

2016

In 2016, the standard payment for Part B will vary. If your 2014 IRS tax return is less than $85,000 (individual) or $170,000 (joint) and you are on Social Security, you will continue to pay $104.90. However, your standard amount will be $121.80, if you fall in either of the following categories:

§ You enroll in Part B for the first time in 2016.

§ You don't get Social Security benefits.

§ Your modified adjusted gross income as reported on your 2014
IRS tax return is greater than a certain amount.

There is also an increase in the IRMAA surcharges.

In 2015, the deductible was $147. This is going up to $166 in 2016. After you have met your deductible, Medicare pays about 80% of the Medicare-approved amount for most doctor services (including those while you may be in a hospital as an inpatient, outpatient therapy, and durable medical equipment) and your plan (most cases GHI) pays the other 20%.

8. Revised Optical Benefit Effective January 1, 2016

Effective January 1, the optical benefit will be increased to $100. The current CSA Retiree Chapter benefit of $55 remains in effect. You may also use any optical provider since the Fund will be terminating its association with participating providers due to administrative costs.

The procedure for using the optical benefit in 2016 is to call the CSA Welfare Fund – 212-962-6061 - and request a voucher. You can also obtain one from the Fund's website, www.csawf.org. When you receive the voucher, sign it, purchase your glasses from any optical provider, and return the voucher with a copy of the receipt for your glasses. You will be reimbursed $100. You do not have to apply for the CSA Retiree Chapter's $55 benefit. The CSA Retiree Chapter will automatically send you the $55 after you receive the $100.

9. Filling Vacation Advance Prescriptions

One of our members recently enlightened me about the problem he had filling a vacation advance prescription at his local network pharmacy. The member was going on vacation and needed the pills in advance because he did not have enough to cover the time he would be away.

After speaking to Express-Scripts, the pharmacy told the member that Express-Scripts does not cover advance prescriptions. The member then called Express-Scripts and was told the same thing. When the member called Emblem Health (his drug plan provider), the individual who answered said absolutely not; advance prescriptions are covered. The individual then called the local pharmacy who filled the prescription.

So be aware. If you are told something that you feel is not true, call the appropriate organizations. This member did just that and had his prescription filled.

10. Shingles Vaccination -

 Non Medicare Members - Get the vaccine and shot from a GHI participating pharmacy (usually CVS or Walgreens). Present your GHI card to the selected pharmacy and have them vaccinate you. GHI will cover the cost of the vaccination.

 Medicare Members - Get the vaccine and shot from a GHI participating pharmacy (usually CVS or Walgreens). Present your GHI card to the selected pharmacy and have them vaccinate you. Although the vaccine is covered by GHI Medicare Enhanced Plan D, you will have a co-pay, the amount depending on what Tier you are in. For example, if you haven't entered the "donut hole," the co-pay will be 25% of the cost of the vaccine or about $50. Check with the pharmacy first to see if it will cover the cost (or part of the course of the vaccination. If it does not, you will be responsible for the full cost and there will be no reimbursement.

11. Marsh (Mercer) Catastrophic Major Medical (CMM) Insurance - As a reminder, this policy is a private one administered by Mercer, which many of you

purchased through NYSUT or AFSA many years ago when you were working in the school system. It has nothing to do with the Fund benefit, Catastrophic Stop-Loss Supplemental CSA Medical Benefit...Mercer recently

sent a Medicare mandated letter to those policy holders who purchased their policy through NYSUT and will be 65 or older, answering questions about the holder's drug coverage under this policy. The letter was intended strictly to be informative. Keep in mind, Mercer's drug coverage kicks in only when you met the deductible ($10,000, $15,000 or $25,000) and will reimburse you up to 100% for reasonable and customary charges for out of pocket expenses.

12. Outpatient Mental Health Services - Recently, Medicare Part B has expanded its coverage of outpatient mental health services to help its beneficiaries with depression and other needs. Medicare will now pay its portion (about 80%) of the cost of certain patient counseling such as group therapy and family counseling, while your supplement pays the rest. Part B will also cover service for treatment of inappropriate alcohol and drug use. Of course, the mental health professionals giving the treatment, have to accept the Medicare assignment. To locate a mental health care professional that accepts Medicate, go online to medicare.gov/physiciancompare and type in your zip code or city and state, then enter the type of professional (psychiatrists, psychologists, clinical social worker and clinical nurse specialists you want to locate in the "What are you searching for?" box. You can also get this information by calling Medicare at 800-633-4227.

13. Signs of a Stroke - If you can spot someone having a stroke and call 911 immediately, there is much better chance that the stroke is treatable and beatable. Signs of a stroke:

a) Face Drooping - One side of the face is drooping or numb.

b) Arm Weakness - One arm is weak or numb.

c) Speech Difficulty - Speech is slurred.

If someone is exhibiting any of these symptoms, call 911 immediately, even if any of these symptoms goes away.

Does Medicare Cover Diabetes Supplies and Insulin? – Medicare will cover diabetic supplies and insulin in different ways. Specifically, Medicare Part B covers certain diabetic supplies known as durable medical equipment (DME) while Medicare Part D covers others. DME coverage requires that you submit a doctor's prescription and obtain the equipment using a supplier that is part of the competitive bidding program or a Medicare-certified provider. Whether you use a supplier who is part of the bidding program or a Medicare-certified provider will depend on the area in which you live.

Below are some of the items Medicare Part B covers:

· Blood sugar monitors
· Blood sugar (glucose) test strips
· Diabetic lancet devices
· Therapeutic shoes or inserts
· Glucose control
 Insulin that is used with an insulin pump

Interestingly, if you inject yourself with insulin, then the cost of insulin and the supplies needed to inject the insulin, including syringes, needles, alcohol swabs, and gauze, will be covered by Part D. Part D will also cover other medications that you use to treat diabetes at home providing the medications are on your Plan D formulary.

Depending on the supplies that you use, Part B or Part D will cover the cost of your supplies or medication. You can get more information from your doctor.