**Informational Update Vol 10 # 8   December 30, 2019**

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**1.   2020 Social Security Letter** – If you are eligible for Medicare, you should have received a letter from Social Security (known as the SSA letter) by now indicating your 2020 Social Security benefit amount before and after deductions. The benefit amount was based on your income in 2018. Other factors that determined this amount included 1) a 1.6 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.

As you know, IRMAA eligibility is based on your taxable income and whether you filed individually, or jointly as a couple. The income that was used to determine eligibility for 2020 Part B & Part D IRMAA was your 2018 taxable income. If you filed individually and your income was greater than $87,000 (up $2,000 from 2019), or jointly and your income was greater than $174,000 (up $4,000 from 2019), you are eligible.

Please note the first page of the SSA letter contains 4 bullets. The first one shows how much your SS benefit for 2020 is before deductions, providing you are collecting Social Security.  The second shows the 2020 deductions for Medicare Part B for the standard amount and for IRMAA (if not eligible for 2020 IRMAA, IRMAA deduction should be 0).

The 2020 Part B standard amount & IRMAA deductions are both reimbursable. You will receive the standard amount automatically, probably sometime in April 2021; you must apply for the IRMAA reimbursement. The application should be available in January 2021.

The 3rd bullet shows the 2020 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.

The 4th bullet lists your SSA benefit amount after all deductions.

If you are eligible for IRMAA in 2020, keep your 2020 SSA letter in a safe place. You will need to include it in the application package when you file for 2020 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. Questions of the Month**

Q. I did not receive my SSA letter listing my 2020 Social Security benefits and deductions. How can I get a copy?

A. There are two ways: 1) you can call Social Security or visit your local Social Security office and request the SSA letter. Have a previous SSA letter or facsimile of the letter available with you so that you can clearly describe to the SSA agent what you want, OR 2) download a copy from the SSA website, www.SSA.com. This will require your having an online SSA account, which, if you don’t have one, you can open one on the SSA website by just following the prompts.

**Informational Update Vol. 10 #7  November 2019**

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**1. 2018 Medicare Part B Differential Reimbursement.**

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In April 2019, the NYC Office of Labor Relations automatically (no application necessary) reimbursed both you, as a Medicare retiree, and your Medicare eligible spouse/legal partner the 2018 Medicare Part B standard premium. The amount of the reimbursement ($1,308) was based on a monthly payment of $109. However, most retirees paid $134 and, therefore, were still owed ($134 - $109) x 12 or $300. This amount is known as the Differential Reimbursement.

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On October 17, 2019, you and your Medicare eligible spouse/legal partner should have received your 2018 IRMAA reimbursement as well as the Differential Reimbursement providing you were eligible for IRMAA reimbursement and filed an application in a timely fashion. The Office of Labor Relations direct deposited the reimbursement check if that is the way you receive your pension or sent you the reimbursement check directly if that is your mode of payment.

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If you are eligible for 2018 IRMAA reimbursement but have NOT yet applied, you can still do so. Just file a 2018 IRMAA application, which can be downloaded from the CSA Welfare Fund website, www.csawf.org and include with it a copy of the November 2017 SSA letter and 2018 SSA-1099 if you collect Social Security. If you do not collect Social Security, you must include proof of payment for the Medicare Part B premium. Credit card statements or copies of canceled checks are acceptable proof.

**How Do I Know If I Am Eligible For 2018 IRMAA Reimbursement?**

You are eligible for 2018 IRMAA reimbursement if your Nov’17 SSA letter, which indicated your monthly 2018 Medicare Part B premium, was GREATER than $134. If you cannot find that letter, look at your Nov’18 SSA-1099. If the amount was GREATER than $1608, you are eligible. Finally, if you cannot find either document, look at your taxable income for 2016, the year in which your 2018 Medicare Part B premium was based on. If the amount was GREATER than $85,000 (filing taxes individually) or $170,000 (filing taxes jointly), you are eligible.

**How Do I Collect the Differential Reimbursement If I Am Not Eligible For 2018 IRMAA?**

If you and your Medicare eligible spouse/legal partner are NOT eligible for 2018 IRMAA reimbursement but paid less than $134 monthly for Medicare Part B, you should have completed a 2018 Differential application to collect the Differential Reimbursement. If you have not done so, it is not too late. Just file the application, which also can be downloaded from the CSA Welfare Fund website, www.csawf.org, and include with it a copy of the 2018 SSA-1099 if you collect Social Security. If you do not collect Social Security, you must include proof of payment for the Medicare Part B premium. Credit card statements or copies of canceled checks are acceptable proof.

**2. Medicare Advantage Plans**

I am sure you have received lots of information in the mail and on TV about Medicare Advantage Plans. Some plans offer unique benefits such as free preventive dental and eye exams, prescription eyeglass coverage, and hearing exam and hearing aid coverage. While it sounds wonderful, it is important to understand that Medicare Advantage plans have both pros and cons.

**What is a Medicare Advantage Plan?**

A Medicare Advantage plan is a private plan that contracts with the federal government to provide minimally the same benefits offered by Medicare, but may operate with a different set of rules, costs and restrictions. Some of the most common plans are Health Maintenance Organizations (HMOs – must use a doctor in the HMO) and Preferred Provider Organizations (PPOs – can use any doctor that honors the plan’s coverage)

The Open Enrollment Period - also known as the Annual Election Period - runs from Oct 15 to Dec 7. During this period, you can switch from Original Medicare to a Medicare Advantage Plan or vice versa, or you can switch from one Medicare Advantage Plan to another.

**Should I Change My Original Medicare Plan to an Advantage Plan?**

 Most CSA Medicare eligible retirees have Original Medicare. If you do, the CSA Welfare Fund recommends you keep it with GHI as your supplement. Original Medicare offers you more flexibility than an Advantage Plan. For example, it allows you to see any doctor of your choice and does not require a referral to see a specialist.

Another negative feature of an Advantage plan is that you no longer will be eligible for Part B Medicare premium reimbursement.

If for some reason, however, you still want to change to an Advantage Plan, I strongly urge you first speak to Doug Hathaway, CSA Welfare Fund Administrator. You will not regret it.

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**Informational Update Vol 10 #6   -- September 17. 2019**

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 1. **2018 IRMAA (Income-Related Monthly Adjustment Amount**

For those who applied for 2018 IRMAA reimbursement in a timely fashion, you should have received a letter from the Office of Labor Relations this past August stating that OLR has received and processed your application, and that you will receive the IRMAA reimbursement sometime in October 2019.

Your reimbursement will be deposited electronically if your pension is deposited electronically or sent to you by physical check if that is how you receive your pension.

If you did not receive this letter, you may have submitted your application late. The application will eventually be processed and payment issued accordingly. If you applied for your Medicare eligible partner/spouse as well as yourself, you received only one letter of acknowledgement.

How Do I Know If I Am Eligible For 2018 IRMAA Reimbursement?

Eligibility for 2018 IRMAA reimbursement is based on what your Medicare Part B premium was in 2016. The premium was listed on the Social Security Administration (SSA) letter you had received in November 2017. If the amount was GREATER than the standard amount of $134 (In some cases the standard amount might have been $109), you are eligible and should have applied for reimbursement.

If you did not apply for 2018 IRMAA reimbursement and are eligible, it is not too late to apply. You can download an application from the CSA Welfare Fund website, www.csawf.org. Be sure to include with the application a copy of the November 2017 SSA letter and the 2018 SSA-1099 Benefit Statement, if you collect social security. If you do not, as of yet collect social security, include proof of payment – either copies of your credit card statement or and/or copies of your cancelled checks.

You can send the completed application and documents to either the CSA Welfare Fund, CSA Retiree Welfare Fund, 40 Rector St., 12th Floor, New York, NY 1006 or the Office of Labor Relations, 22 Cortlandt St., 12th Floor, New York, NY 10007. Send the materials 1st class, receipt requested.

 2. **CSA Welfare Retiree Fund Optical and Hearing Aid Benefits**

 Are you looking to buy new glasses or hearing aids? Before you do, keep in mind that you have excellent Optical and Hearing Aid benefits.

         **Optical Benefits** – You are entitled to an optical benefit every 12 months. The CSA Welfare Fund reimburses $100 while the CSA Retiree Chapter reimburses an additional $65, for a total of $165. To receive the optical benefit, do the following:

·        Obtain an optical voucher. You can request the voucher from the CSA Welfare Fund website (click on the link, “Request a Voucher”), or call the Fund, 212-962-6061.

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

·        Sign and date 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 one in exchange for a new voucher.

After the Fund reimburses you $100, you will automatically receive a $65 check from the Retiree Chapter about 2 weeks later. You do not have to apply for the Chapter reimbursement.

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      **Hearing Aide Benefits** – The CSA Welfare Fund will reimburse you up to $800 for hearing aids every 36 months. In a seamless operation, the CSA Retiree Chapter will also reimburse you up to $800 every 3 years. 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.

In order for the Fund to reimburse you, you will need to get a voucher by requesting it from the website or calling the Fund. The voucher is used the same way as the optical voucher: sign and date it and submit it along with proof of payment and an itemized bill to the Fund. If you use a participating hearing aid center, the Fund will pay them up to $800, otherwise they will reimburse you.

**Question of the Month**

Q: Although I am eligible, I never applied for IRMAA reimbursement. Is it too late to do so?

A: Partially. You can still apply for years 2016, 2017 and 2018. Nothing before those dates. Just check the appropriate box on the application for the year you are applying and be sure to include the proper documentation.

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**Informational Update Vol 10 #5  July 2019**

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1. Medicare Coverage Outside of the USA – At this time of the year, many retired people take cruises outside of the USA. If you are, you must consider your medical coverage once you leave 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, Medicare may pay for inpatient hospital, doctor, ambulance or dialysis services in some rare cases.

1. You're in the USA when a medical emergency occurs, and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.

2. You live in the USA, but a foreign hospital is closer to your home than the nearest U.S. hospital, regardless of whether it is an emergency.

In some cases, Medicare may cover some medical situations on-board a ship if you are in territorial waters adjoining the land areas of the USA and no further than 6 hours from the USA.

Medicare does not cover any prescription drugs outside of the USA

Do I Have Any Coverage Other Than Medicare Outside the USA?

Yes, you probably do. If you have GHI as your secondary coverage, it will cover medical expenses as follows:

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.

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 and Medicare virtually none, I highly recommend you obtain travel insurance before traveling abroad.

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**2. “Hard Caps” vs “Soft Caps”** – One of the most confusing improvements in Medicare has been the replacement of the Medicare therapy “hard cap” for physical therapy, speech therapy & occupational therapy with a “soft cap.” In fact, some therapists are unaware of this important change or how it even works, causing great consternation to people who need extensive therapy.

In 1997, Medicare introduced a therapy limit or “hard cap” of $1,500 for out-patient therapy services. When the “hard cap” was reached, therapy was generally no longer covered. If someone needed therapy beyond the “hard cap,” therapists could apply for an exception, but was not always successful. Fortunately, the $1,500 cap got larger and larger over the years and eventually became a “soft cap.”

“Hard Cap” Replaced With “Soft Cap”

In the 2018, Congress repealed the “hard cap” and replaced it with a “soft cap.”  That meant it became much easier for someone in need of extended therapy to get approval beyond the Medicare threshold (in 2018 it became $2,010, in 2019 it rose to $2040).

Steps That Need to be Taken to Get Approval for Therapy Services Beyond the Threshold

1.The Doctor must write a letter confirming the patient needs therapy services beyond the threshold by a skilled therapist.

2. The therapist must continue to track the patient’s progress so that he or she can submit a claim (requires special code) for extended therapy services.

In conclusion, if a therapist says you reached the limit in therapy services, remind him or her that Medicare now has a “soft cap.” If approval to get extended therapy hours is not possible, you can always use the CSA Welfare Fund benefit for therapy coverage.

**3. Question of the Month** – I have used a health aide for the past 5 years and paid him by cash. Only in the last month did I start paying by check. Am I entitled to a reimbursement for the 5 years I was paying by cash?

Answer – Unless you have receipts showing you paid cash to the aide, the cash payments are not reimbursable. The CSA Welfare Fund will not pay out a benefit unless there is evidence of payment. However, paying by check is reimbursable since your bank statement is evidence of payment.

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**Informational Update Vol 10 #4  May 18,2019**

**1. 2018 Medicare Part B Differential Reimbursement**

You and your Medicare-eligible dependent spouse/legal partner (if any) should have automatically (no application necessary) received the 2018 standard Medicare Part B reimbursement on April 12. This was directly deposited, or if you do not use direct deposit, mailed to your home.

The amount of the reimbursement was either $1,308 or $1,608, depending on when you went on Medicare. If you went on Medicare during or after January 1, 2017 you received the correct amount of $134 per month, $1,608 for the full year (pro-rated if you were not on 2018 Medicare for the full year).

However, if you went on Medicare prior to January 1, 2017, you most likely received $109 monthly, $1,308 for the full year. The amount was incorrect since you probably paid more than $109 for Medicare part B in 2018. Consequently, you would be entitled to an additional Part B reimbursement, known as the Part B Reimbursement Differential. The amount of the Reimbursement Differential probably is $300 (($134-$109) x 12) since most Medicare-eligible members paid $134 monthly for 2018 Medicare Part B.

How to request your 2018 Medicare Part B Reimbursement Differential

This month, the CSA Retiree Welfare Fund mailed a 2018 Medicare Part B Reimbursement Differential form. If you qualify for 2018 IRMAA (monthly Part B premium more than $134 in 2018) and have filed for 2018 IRMAA, DO NOTHING. The differential will be included in your IRMAA reimbursement scheduled for October 2019. If you have not yet filed for IRMAA please do so NOW and submit the required documents to the Retiree Welfare Fund, which will verify the correctness of your application & documents.

If your monthly 2018 Part B premium was greater than $109, but you DID NOT QUALIFY FOR IRMAA, complete the Reimbursement Differential form and submit it along with the proper documents to the Retiree Welfare Fund.

The differential, which in most cases should be $300, will be reimbursed in the first quarter of 2020.

Remember, the differential is only for Medicare-eligible members whose standard reimbursement was $1,308 and paid more than $109 monthly for 2018 Medicare Part B.

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    **2. Question of the Month: Does Medicare Cover Ambulance Services?**

    Definitely in an emergency when your health is seriously impaired and you cannot be transported safely by any other means but by ambulance, Medicare Part B will also cover ambulance services in certain non- emergency situations.

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Part B Coverage of Emergency Ambulance Services

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Part B will cover such services provided:

·        It is the only safe way to travel to a hospital or skilled nursing facility (SNF)

·        The reason for the trip is either to receive a Medicare - approved service or return from receiving service. The transportation must be from Medicare approved locations such as your home to the hospital and back.

·        The transportation provider meets Medicare ambulance requirements.

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Part B Coverage of Non-Emergency Ambulance Services

Part B will cover such services if the person:

o   Is confined to a bed, e.g., cannot get up without help, and unable to sit in a chair or wheel chair.

o   Needs essential medical services during the trip that can only be done in an ambulance

       Please note that Original Medicare Part B does not cover the ambulette services, wheelchair van, or litter vans.

**Informational Update Vol 10 #3  --  April 7, 2019**

**1. “Valentine” 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 2018 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 as a check. Those who were eligible for reimbursement, but were not on Medicare for the full year, should have received a pro-rated check. The pro-ration is $40 a month for every month on Medicare.

Eligible Retired CSA members 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; non-CSA Medicare eligible people are not. If both husband and wife are Medicare eligible CSA retirees, then both are entitled to the $480 providing EACH has their own NYC medical coverage. If one member is covering the other member, then only the member who is covering is entitled to the $480.

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 automatically (no filing of a claim necessary) supplements this reimbursement with an additional 20% of the Fund payment.

**2. Good News – Increase in Welfare Fund Benefits**

Once again the CSA Welfare Fund has come through for the members by enhancing 2 very important benefits.

**1)    Home Health Aide** - Effective January 1, 2019, the benefit has risen to a maximum of $10,000 per year, $30,000 lifetime. This represents an increase of $2,000 per year and $6,000 lifetime. As it did previously, the CSA Retiree Chapter will reimburse you in a separate check an additional 20% of what the Fund reimburses you.

How does the benefit work and how do you file a claim?

After a $100 deductible, the CSA Welfare Fund will reimburse you 80% of your cost up to the $10,000 annual maximum. To file a claim you will need to submit to the Fund (nothing needed for the Chapter):

·        A doctor’s prescription showing the need for the aide.

·        Proof the aide is certified.

·        A log of the date and hours the aide provided service.

·        Proof of payment. You will need a copy of a credit card or check payment. Cash payment is not acceptable.

·        A completed Home Health Aide form. You can obtain a blank form from the CSA Welfare Fund.

Within about 2-3 weeks after you receive the Fund reimbursement, you should receive the Chapter reimbursement.

**2)  Acupuncture Visits**

a. The number of reimbursable visits has risen from 18 to 36 effective January 1, 2019.

b. Also, effective the same date, the maximum allowable charge is $100 per visit. As for the Home Health Aide benefit, the cost is reimbursed at 80% after an annual $100 deductible. Also, the Retiree Chapter will continue to reimburse you 20% of the Fund reimbursement.

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**Informational Update Vol 10 #2 (March 5, 2019)**

**1. Medicare Part D Drug Costs**

The GHI enhanced Medicare Part D drug plan consists of Tiers 1, 2 & 3. If you noticed a change in your prescription costs it may be due to your starting again in Tier I on January 1, 2019, even if you ended on December 31st, 2018 in another Tier. In Tier I, you pay 25% of the drug cost while the plan (GHI enhanced Plan D) pays the other 75%.

If your total drug cost (what you and your plan both pay) exceeds $3,820 (up from $3750 in 2018) at some point in 2019, you enter Tier 2, known as the donut hole.

During the past several years, the donut hole has become smaller and smaller. In 2019, it closed for brand name drugs, i.e., you continue to pay the same 25% drug co-payment as you do in Tier I. However, your generic drug co-payment is affected; you will pay 37% of the drug cost with your plan paying the remaining 63%. For example, if a drug cost $100 in Tier I, your co-payment is $25 (25% of $100). In Tier 2, your co-payment becomes $37 (37% of $100).

If your true-out-of-pocket expense – known as TrOOP – for both Tiers 1 & 2 exceeds $5,100 (up from $5,000 in 2018) you enter Tier 3, or the catastrophic coverage. In this Tier your co-payment continues as it was in 2018 at 5% of the drug cost. Medicare pays 80% and the plan pays the remaining 15%.

The CSA Welfare Fund also offers an added benefit in this Tier by reimbursing you the 5%, cost up to $5,000. There is no deductible. Just send your Express Scripts statements to the CSA Welfare Fund for reimbursement. These statements should be sent at the end of the calendar year to help facilitate the CSA Retiree Fund’s processing of your request.

**2. Medicare Part D Coverage**

You go to your pharmacy with a prescription for a drug you never took before only to be told by the pharmacist that the drug is not on your plan’s formulary (list of drugs your plan covers). What do I do now?

To begin, you should have checked that your plan covered the drug. This can be done by asking your doctor, calling your plan, or checking your plan’s website. For example, if your plan is GHI Enhanced Medicare Prescription Drug Plan (most CSA retirees have this plan) you could do a google search for “GHI drug formulary 2019” to determine if the drug is covered.

If you determined the drug is not covered, you can go back to the doctor and ask if he/she could prescribe an equivalent drug that is on the formulary (preferred drug). If there is no equivalent drug, you can file for an exception to your plan’s formulary. Have your doctor write a letter supporting your use of non-covered drug, explaining why you need this drug and why you cannot use any other. The reason for not using a different drug might be it is too dangerous or less effective. If your request for an exception is turned down, you can file an appeal. You can find instructions on how to file an appeal process on the Medicare website, www.Medicare.gov

If it applies, you can also ask your pharmacist for a temporary supply of the drug through your plan’s transition refill policy. This option requires that your drug was covered before you switched plans or covered before the plan changed its coverage rules.

Finally, if none of the above works, call the CSA Welfare Fund to see if there any other options.

**3. Most Popular Question Asked This Month**

Q. I live in Sarasota and have an appointment with a non-Medicare chiropractor. Am I eligible for any reimbursement from the CSA Welfare Fund?

A. The CSA Welfare Fund’s Stop-Loss benefit provides coverage in such instances. However, there is a $1,000 deductible. For the next $1,000 you get back 80% of what is considered a reasonable cost (what Medicare pays). After that you get back 100% of what is considered a reasonable cost up to $50,000 annually, $250,000 lifetime. The Retiree Chapter reimburses an additional 20% of what the Welfare Fund reimburses – up to an additional $10,000 annually, $50,000 lifetime.

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**Informational Update Vol 10 #1 (January 25, 2019)**

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**1    2019 Medicare Part B Deductible & Premiums –**

As you start to visit your Medicare doctors in 2019, you will have to pay deductibles again as they reset January 1.  The deductible for Medicare increased $2.00 from $183 to $185. (GHI remains at $50). The portion of the $185 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 increased $2.00 from $134 to $135.50. If your monthly taxable income is greater than certain threshold amounts, you will pay, in addition to the standard Medicare Part B premium, a surcharge known as the income-related monthly adjusted amount or IRMAA.

The good news is that BOTH the standard and IRMAA amounts are still reimbursable. The Office of Labor Relations (OLR) automatically reimburses the standard amount, however, you must apply for the IRMAA reimbursement.

**How do You Apply for 2018 IRMAA**

If you are eligible for 2018 IRMAA reimbursement, the application is now available on the CSA Welfare Fund website, www.csawf.org. Please note that you must check which year you are applying for reimbursement. (You can apply separately for 2016 or 2017 IRMAA reimbursements if you never did so and were eligible.) Also, it is critical that you sign the application or else it will not be accepted.

Documents To Be Included With Application:

There are two (2) documents that must be included with the application you are submitting for reimbursement. These documents are:

1) The letter Social Security (SSA) sent you, dated November 2017, indicating how much your Medicare Part B premium was going to be in 2018. (Do not confuse this letter with the one you received this past November, which indicated your 2019 Medicare Part B premium.)

2) The SSA-1099 letter you have received, or will receive shortly, indicating the total amount you paid for your Medicare Part B premium.

Please Note:

1. If your spouse or significant other is 1) Medicare eligible, and 2) a city retiree who has his/her own medical coverage, he/she must fill out and sign a separate application and submit it along with the proper documents.

2. If your spouse or significant other is 1 Medicare eligible, and 2) is your dependent, complete the Eligible Dependent Information section on your application (one application for both of you) and submit it along with your proper documents as well as your spouse’s or significant other’s proper documents. This procedure is to be followed whether or not your spouse or significant other is a city retiree.

3. If you or your Medicare eligible spouse are not yet receiving Social Security, you will not receive a 1099 form. Instead, you will have to send a copy of each month’s SSA billing statement for Medicare Part B and proof of payment for the IRMAA premium (copy of check, credit card statement, or bank statement). If you are providing a credit card or bank information black out the account information before submitting the information.

Who Gets the IRMAA Application?

Once again, you can send your application to the CSA Welfare Fund. The Fund will check your application to determine that you submitted the correct documents. They also will scan your documents (in case the city loses your submission) to their archives, and, log and submit them to OLR. You can, if you wish, submit your application directly to OLR.

**When Will I Receive My IRMAA Reimbursement?**

If all goes well, you should receive it in October 2019.

Reminders:

1) Do not submit original documents. Only copies.

2) Make a copy of your submission(s) and put it in a safe place.

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.

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**Informational Update Vol 9 #8 (November 2018)**

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**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.

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**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.

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**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 #5   June 2018**

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**1. Medicare Part B Differential Reimbursement**

Last month, your standard Medicare Part B reimbursement for 2017 (and your Medicare eligible dependent, if any) was directly deposited into your bank account or, if you did not use direct deposit, mailed to you. However, you may have received less than what you paid for Part B because the reimbursement was based on a standard premium of $109 per month instead of what most CSA Medicare eligible retirees paid, $134 per month.

How to Receive the Differential Reimbursement

 Recently, you received a letter from the Office of Labor Relations (OLR) explaining how you can apply for the differential reimbursement. If your Part B premium was between $110 and $134 and you applied or will apply for 2017 IRMAA reimbursement, DO NOT FILL OUT THE FORM that is on the back of the letter. The differential reimbursement will be sent to you automatically. We were told you would receive the reimbursement in November 2018. Also, DO NOT FILL OUT THE FORM if you went on Medicare in 2016 or later. The reason is that you were already fully reimbursed, i.e., you received reimbursement based on your $134 premium.

If your Part B premium was between $110 and $134, but you were not eligible for 2017 IRMAA or did not receive Social Security, YOU MUST complete and submit the form to receive the differential reimbursement. Because of the large quantity of letters OLR is expected to receive it is anticipated you will receive the reimbursement in March 2019.

**2. Coverage for Dependent (Surviving) Spouses of CSA Retiree Members – Part 2**

 Last month, I wrote about some of the benefits a Medicare-eligible surviving spouse, whose Medicare-eligible CSA retiree predeceased him or her, is entitled to. This month, I will review a CSA Welfare Fund & CSA Retiree Chapter benefit that pertains only to Medicare eligible surviving spouses, the drug cost benefit.

After a $100 annual deductible, a Medicare-eligible surviving spouse, who has continued with a city health plan through Cobra or has his or her own health plan that includes drug coverage, is entitled to being reimbursed 80% of the drug cost up to $5,000 max for the year. Because of the large volume of requests for reimbursement, I would suggest the spouse submit his or her request at the end of the year. The request should include the print-outs from the drug plan provider.

The CSA Retiree Chapter will also reimburse an additional 20% of what the Fund reimburses, providing the spouse has joined the chapter. This is a seamless operation that does not require submitting anything to the chapter. The spouse will receive the check from the Chapter about two weeks after being reimbursed by the Fund.

A surviving spouse is also entitled to many other CSA Welfare Fund supplemental benefits for a period of 5 years, at no charge after the member has past. After the 5 years, the spouse can continue these benefits by paying the Cobra rate. If the spouse joins the CSA Retiree Chapter he or she will be entitled to an additional 20% of what the Fund pays for many of the Fund benefits.

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**Coverage of Physical (PT), Speech-Language Therapy (SLP) or Occupational Therapy (OT)**

Original Medicare will cover your outpatient skilled therapy (PT, SLP, or OT) as an outpatient providing you meet certain criteria:

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* ·         You need skilled therapy as a result of your physical condition.
* ·        Your doctor or therapist develops a health care plan before you start the     therapy.
* ·        Your doctor or therapist regularly reviews the plan and makes changes as needed.

Previously, original Medicare had caps on how much outpatient therapy service it would cover. However, this changed in 2018 when the caps were removed. Despite this change, if your total outpatient therapy costs reach a certain plateau, Medicare requires your doctor to indicate you medically need the therapy before you can continue. These plateaus are:

* §    $2,010 for PT and SPL. If you need more therapy, your doctor will have to indicate it is medically necessary. Even though your doctor may have indicated the need for more therapy, check with Medicare before continuing the therapy.
* §    $2,010 for OT. If you need more therapy, your doctor will have to indicate it is medically necessary. Even though your doctor may have indicated the need for more therapy, check with Medicare before continuing the therapy.

 Keep in mind that outpatient facilities include:

1. v Your own home with a licensed therapist
2. v Comprehensive Outpatient Rehabilitation Facilities (CORFs}
3. v A therapist or doctor’s office, and
4. v A skilled nursing facility where you are there as an outpatient

​Informational Update Vol 9 #4

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**1. CSA Welfare Fund Stop-Loss Benefit**

As retired CSA members, we are quite fortunate to have outstanding CSA Retiree Fund & CSA Retiree Chapter health benefits. In my view, one of the best of them is the Stop-Loss benefit. Why? Because it limits the member’s out-of-pocket medical expenses. Let’s see how it works.

First, the benefit reimburses medical expenses not covered by the Basic NYC Health Plan, including office visits and lab charges. For Non-Medicare members, it also includes “all deductibles and co-insurance charges applied by GHI, Blue Cross, and the Welfare Fund, exclusive of hospital charges other than the $300 per admission deductible.”

Second, after a $1,000 deductible (annual), you are reimbursed 80% of the next $1250. Thereafter, you receive 100% of your remaining out-of-pocket expenses up to $50,000 annually/$250,000 lifetime. Also, the CSA Retiree Chapter will reimburse you 20% of the Welfare Fund payment. Keep in mind that Stop-Loss does not cover hospital costs.

 As an example, suppose you put in a claim to the Retiree Welfare Fund for a $3,000 out-of-pocket expense. If this is your first claim for the year, then you pay a $1,000 deductible. You get back 80% of the next $1250 expense or $1,000 plus 20% of $1,000 or $200 from the Retiree Chapter. You get back 100% of the remaining $650 expense. Thus, your total out-of-pocket expense is $1,000 + $50 ($1,250 - $1,200) or $1,050. And, that’s it for the ye

While the benefit sounds great, and it really is, there are some hitches. First, the out-of-pocket expenses must be reasonable and customary. You will not get back what you think you should if it is not. Second, if you are on Medicare and choose not to use a Medicare doctor, the allowance will be based on Medicare rates or even less. If there is no Medicare doctor available, then the rate could be much higher. In this instance, I strongly recommend you call the Fund to determine the rate of the reimbursement.

**2. Medicare Summary Notice**

Did you ever receive a Medicare document called a Medicare Summary Notice (MSN) and think it was a bill? If you did, you are not alone. However, the good news is the MSN, which generally shows exceptionally high charges, is NOT a bill.

The MSN is a summary of health care services you have received in the previous 3 months. Medicare will usually send you one 4 times (quarterly) a year. The document may have the name and address of a private company on it. You will not get one if you did not receive medical services in the previous 3 months.

Generally, a MSN contains charges billed to Medicare, the amount Medicare paid, and the amount you are responsible for. Your supplement, like GHI, will most likely cover your responsibility unless the MSN lists a non-covered charge. If you feel the charge is unwarranted, you may appeal it.

Save your MSNs. You may need them in the future to prove payment was made. If you lost a MSN or need a duplicate copy, call 1-800-MEDICARE. You may also retrieve it online at www.mymedicare.gov. However, to do so requires having an online Medicare account, which you obtain on the website.

**3. Coverage for Dependent (Surviving) Spouses of CSA Retiree Members (Part I)**

I recently received a call from a surviving spouse of a Medicare-eligible CSA retiree, informing me that her doctor told her she is no longer covered by her secondary insurer, GHI (Medicare was primary). To explain why this happened, let me review the coverage of a dependent spouse.

The city provides free basic medical coverage for all retired CSA members as well as their dependent spouses. If the dependent spouse is on Medicare, then the coverage is a secondary insurer, which in most cases is GHI.

A dependent spouse is also entitled to the CSA Welfare Fund and CSA Retiree Chapter benefits.

What happens when a CSA retiree member pre-deceases his or her dependent spouse? To begin, the surviving spouse’s medical coverage immediately stops, although generally there is a 2 month grace period. Fortunately, the spouse can purchase the city basic coverage upon the death of the CSA member for up to 3 years. The purchase falls under the provisions of the Federal Cobra regulations. (In the case I described above, the caller thought she was medically covered for life only to find out she wasn’t). After the three years, the spouse will have to pay the full price for the medical coverage