Informational Update Vol 14 #6 June 30, 2023

1. Aetna: Retiree Special Enrollment /Waiver Form

The Office of Labor Relations has introduced a Retiree Special Enrollment/Waiver Form intended for:

- **NYC Medicare-eligible retirees who have HIP VIP Premier Medicare HMO (only people who live in the NYC metropolitan area - the 5 boroughs, Nassau, Suffolk, and the Westchester, Rockland, and Orange counties - are eligible for this coverage) and wish to enroll in the Aetna Medicare Advantage (PPO) Plan.**
- **NYC Medicare-eligible retirees who wish to add the Aetna Medicare Advantage Plan Prescription Drug Rider for prescription drug coverage. (Effective September 1, 2023). These are for retirees who have a private Medicare Part D plan for which they will no longer be eligible.**
- **HIP VIP members who wish to add the HIP VIP Prescription Drug Rider (Effective Sept 1, 2024). These are for retirees who have a private Medicare Part D plan for which they will no longer be eligible.**
- **NYC Medicare-eligible retirees who wish to waive (terminate) their NYC Health Plan instead of automatically transitioning to the Aetna Medicare Advantage Plan on September 1, 2023. By waiving their health plan, these retirees are giving up their annual Part B premium reimbursement (standard and, if applicable, IRMAA) as well as their $480 "VALENTINE'S GIFT to help pay for the drug rider.**

If any of the above categories are applicable to you, you will need to fill out this special form. This includes 1) filling in the profile information, 2) checking the appropriate box, and 3) signing your name.

The date when the application is due has been extended from June 30, 2023 to July 10, 2023. Mail form to: NYC Health Benefits Program 22 Cortland Street, 12 th Floor

THOSE NYC MEDICARE ELIGIBLE RETIREES WHO LIVE OUTSIDE THE NYC AREA (e.g. ARE NOT TO FILL OUT THIS FORM UNLESS THEY HAVE A PRIVATE MEDICARE PART D. IN THAT CASE, THEY SHOULD CHECK OFF OPTION 2 ON THE FORM.

2. Surviving Spouses/ Registered Partners

During the course of the year, I receive many calls from members' non-CSA surviving spouses/registered partners about whether they are still entitled to the CSA Welfare Fund benefits. As a result of so many calls, I am re-printing the article I wrote on this topic last year.

While the passing of a member is a very difficult time for the surviving spouse/registered partner, the good news is that the CSA Retiree Welfare Fund continues to provide him/her with supplemental medical coverage WITHOUT COST for a period of 5 years from the date of the member's passing. The only condition is that the surviving spouse/registered partner must have a basic city health plan or the equivalent through another health plan to receive the Fund coverage. Also, the Fund's retiree benefits stop before the 5 years should the survivor remarry.

The Fund coverage includes dental, optical, hearing aid, drugs, and many other medical items. The whole list of benefits can be downloaded from the CSA Welfare Fund website.

Surviving spouses/registered partners are also entitled to the CSA Retiree Chapter supplemental benefits. However, to enjoy these extra benefits, the surviving spouse/registered partner must join the Chapter. While being a member of the Chapter has a monthly charge, it is money well spent since the Chapter benefits will greatly enhance the Welfare Fund benefits

After 5 years from the member's passing, the Welfare Fund supplemental benefits automatically end unless the surviving spouse/registered partner extends the benefits by paying a monthly COBRA premium. This extension will be necessary if the surviving spouse/registered partner belongs to the CSA Retiree Chapter and wants to continue to get their supplementary medical benefits.

3. Question of the Month

Q. How do I know if I am entitled to 2022 IRMMA reimbursement?

A. Do one of two things: • Look at the 2021 November SSA verification letter. It will show what your standard premium is and, if applicable, your IRMAA surcharge. If there is a surcharge, you are entitled to an IRMAA reimbursement. • Look at your 2022 1099 SSA letter. In 2022 the standard amount was 170.10 per month or $2,041.20 a year. If the amount listed on the letter is greater than the yearly amount, then you paid an IRMAA surcharge and are entitled to an IRMAA reimbursement.

Informational Update Vol 13 #6 May 22,2023

1. 2022 IRMAA Application

The 2022 IRMAA application is now available. You can also download the form from the CSA Welfare Fund website, www.csawf.org. This application may also be used for the years 2020 & 2021.

Please make sure to include the following with your 2022 IRMAA reimbursement request.

1) A completed reimbursement request application. Be sure to check off 2022 and sign and date the application. If your spouse/domestic partner is your dependent, be sure to complete the Eligible Spouse/Dependent section of the application. If your spouse/domestic partner is also a NYC retiree and has a separate NYC health plan, then she/he has to submit a separate reimbursement request application.

2) The **November 2021** Social Security Award letter. This is the annual letter that tells you how much Social Security you will be receiving the following year (in this case 2021) & your Medicare Part B & D premiums.

3) The **2022 Social Security 1099 letter.** Please note that if you went on Medicare in 2022, you are entitled to a prorated 2022 IRMAA reimbursement. Also, if you never applied for IRMAA reimbursement for 2020 and/or 2021, you may use the same 2022 IRMAA application but mark off the year in question and submit each year's request in a separate package.

So, for example, if you are applying for 2020, 2021 & 2022 IRMAA reimbursement, submit 3 separate packages. Each package will contain 3 documents; an application, appropriate SSA letter (for 2020, the November, 2019 letter and for 2021 the November 2020 letter), and appropriate SS 1099 letter (for 2020, the 2020 SS 1099 letter and for 2021, the 2021 SS 1099 letter.

2. **Aetna's Continuity of Care Transmission Assistance & Authorization for Release of Protected Health Information (PHI} Forms**

Two of the most important forms Aetna has sent to its Medicare-eligible members have been the Continuity of Care form and the Release of PHI form. If you (or your dependent) are planning an operation after September 1, 2023 (when Parts A & B of Aetna plan goes into effect) or you have an ongoing critical care situation, such as receiving chemotherapy or dialysis, it is important that you complete the Continuity of Care form. This form collects the data that will alert Aetna to your situation and will help keep your ongoing medical care uninterrupted, including maintaining ongoing prescription specialty medicine.

When you complete and submit this form in the envelope that Aetna provided, a nurse case manager should reach out to you to ease the transition to the new Aetna Medicare Advantage PPO plan. To help ensure this happens, check off the box on the form, Request to Speak to a Nurse Case Manager.

If you have not received the Continuity of Care form you can download one from the CSA Welfare Fund website and submit the completed form to:

Attn: City of NY F314 Aetna

P.O. Box 818013

Cleveland, OH 44181-9920

Or you can email to: CONYMailbox@aetna.com.

Aetna recently mailed out an Authorization for Release of PHI form to those members who had submitted a completed Continuity of Care form. If you received the PHI form, be sure you complete and submit it to Aetna.

Included with the PHI form was an outreach letter in which Aetna confirmed they will work with you and your physicians to ensure quality medical care and that you will be "covered for any upcoming care or procedures." The letter also included a support plan for your physical, emotional and social health.

If you have submitted a Continuity of Care form but did not receive the authorization form then either call Aetna, 855-648-0389 or email Aetna at CONYMailbox@aetna.com.

3. Question of the Month

Q. I recently received a bill of $84 from my doctor who claims that was my deductible. However, I already paid my complete deductible previously. How could that discrepancy happen?

A. At the time you received service from the doctor, you still had not exhausted your deductible and so he charged you accordingly. However, the doctor apparently held on to the bill and by the time you received it, other doctors that you had gone to already used up your deductible. Consequently, you do not owe the $84 and the doctor will have to re-file the bill with Medicare. Motto: Keep track of your deductibles.

Informational Update Vol 14 #4 April 20,2023

1. 2022 Medicare Part B Reimbursement

On or around April 14, 2023, Medicare-eligible retiree members and their Medicare-eligible dependents received the annual Part B standard reimbursement for 2022 of $2,041.20 ($170.10 x 12 months). Those who went on Medicare sometime during 2021 will receive a pro-rated amount, although the exact date when this will happen is unknown at this time.

Those members who receive their pension payments electronically should check their bank account for the payment. Those members who receive their pensions by check, should have received the reimbursement the same way.

Unlike IRMAA, the standard reimbursement is automatic and requires no application providing the Office of Labor Relations (OLR) has a copy of your Medicare Parts A & B card. As a courtesy, the CSA Retiree Welfare Fund will send OLR a copy of your card providing you first send the Fund a copy.

2. 2022 IRMAA

Federal law requires Medicare-eligible retirees to pay a surcharge on top of the Part B standard amount and Part D (drugs) premiums if their taxable income surpasses a certain amount. This surcharge is called the Income-Related Monthly Adjustment Amount (IRMAA). Part B IRMAA is reimbursable, but unfortunately, Part D is not.

In order for you to receive the Part B IRMAA reimbursement, you must file a completed NYC IRMAA reimbursement application. The Office of Labor Relations (OLR) has said that this application will be available sometime between the end of April and the beginning of May. The CSA Retiree Chapter will let you know when the applications are available.

3. Aetna Medicare Advantage Plan (PPO) – Prior Authorization

A sensible discussion concerning Prior Authorization requires first understanding what it is in healthcare.

Prior Authorization (PA) is a process in which the health provider must obtain prior approval from your health plan before prescribing a particular medical procedure or medication. If this approval is not obtained for the treatment, your health plan may not pay the provider, leaving you responsible for the full payment. Under traditional Medicare, which rarely requires a PA, you may have to sign a waiver for a particular procedure or medication. The waiver makes you responsible to pay if Original Medicare will not pay for the treatment.

Health plans have their own rules as to which medical services require medical services. Under the new customized NYC Aetna Medicare Advantage Plan, which begins September 1, 2023, many of the services that required PA under the previous NYC Advantage Plus Plan are no longer required. These include MRIs, CT Scans, PET Scans, Diagnostic cardiology, sleep study, pain management, physical therapy, occupational therapy, speech therapy and radiation. In short, most of the PAs have now been removed.

4. Question of the Month

Q. I recently came home from the hospital after emergency surgery and have been using a Home Health Aide for my personal needs. Does the CSA Retiree Welfare Fund reimburse my costs for the aide?

A. Sorry to hear about your surgery. I'm happy to tell you that you are entitled to Home Health Aide benefits under the CSA Retiree Fund as well as the CSA Retiree Chapter. Here is how it works: after a $100 deductible, the Fund will reimburse you up to 80% of the cost to a maximum of $10,000. There is a lifetime maximum of $30,000. On top of that, the CSA Retiree Chapter will pay you an additional 20% of whatever payment you receive from the Fund seamlessly. The Chapter has no deductible

To receive these benefits you will have to submit a completed Home Health Aide form (attached) to CSA Retiree Welfare Fund. The form will ask for a doctor to describe the need for an aide. Also, the aide must be certified and should be paid only by check or credit card.

Once you receive a check from the Fund, you will receive a 2nd check from the Retiree Chapter shortly thereafter.

Informational Update Vol 14 #3 1. 3/28/2023

Aetna Medicare Advantage PPO Plan (AMAP)

In early March of this year, the Municipal Labor Union approved the Aetna Medicare Advantage PPO Plan (AMAP), paving the way for the city to transition Medicare-eligible members and their Medicare-eligible

dependents to this plan. Once this plan goes into effect, there will only be two city health plans: AMAP and HIP VIP.

AMAP is required to cover all Part A and Part B services. All Medicareeligible members, except HIP VIP Premier Medicare members, will automatically be enrolled in this plan on September 1, 2023.

AMAP also includes a prescription drug plan offered by SilverScripts. Medicare-eligible members and their Medicare-eligible dependents currently enrolled in the GHI Enhanced Plan D, will remain in this plan until December 31, 2023. Then, on January 1st, 2024, this group will automatically be enrolled in the Aetna drug plan.

If Medicare-eligible members and their Medicare-eligible dependents do not have a Senior Care drug rider, and instead, are enrolled in a different City drug prescription plan, they will also be automatically enrolled in the Aetna drug prescription plan. However, the enrollment date is September 1, 2023.

Once AMAP was approved, Aetna produced a plethora of information for the members to absorb. In addition, Aetna scheduled many meetings in various formats including Web conferences, Teleconferences, and inperson meetings. In addition, members can listen to prerecorded meetings of previous Aetna presentations and learn all about the plan.

This past week Aetna sent you a pamphlet, Join Us, which lists the schedule of each of these meetings. If you want to view a prerecorded meeting, visit Aetna's website, www.CONY.AetnaMedicare.com, for the link which appears toward the bottom of the website. Then click Webinar, check the box next to City of New York and Aetna Retiree Informational Session, Register, and click the URL for the presentation. If you did not receive this publication, you can also get the schedule from Aetna's website, www.CONY.aetnamedicare.com, calling the Aetna hotline telephone number at 855-648-0389, or from the CSA Welfare Fund website, www.csawf.org/aetna.

When you call the hotline number, you will also be able to ask questions about:

- Doctors/providers not showing in the look-up tool
- Coverage for a specific drug or procedure
- Locations of hospitals and urgent care centers in the network
- Prior authorizations

Because AMAP is new & unique health plan that impacts so many members, I plan to discuss various aspects of it in future Updates. In the meantime, I strongly suggest you become familiar with the documents that are

online on the CSA Welfare Fund website (www. csawf.org/Aetna) and attend one of the scheduled Aetna meetings.

Also, for further information, please SAVE THE DATE for a unique CSA Hybrid Aetna Presentation on April 27, 2023. An additional email will go out with an opportunity to register for an in-person seat at CSA Headquarters or a Zoom link. Questions will be collected in advance and throughout the presentation.

2. The Value of the CSA Retiree Welfare Fund and CSA Retiree Chapter Benefits

Two years ago, I wrote about the value of our retiree benefits. Because there have been so many retirees since then, I decided to reprint the article.

I often talk about how our CSA Retiree Welfare Fund and CSA Retiree Chapter Fund offer some of the best retiree benefits you can find anywhere. But how good are they really? To answer that question I decided to see if I could put a monetary value on these benefits. To do this, I added all the monies that were listed on the document that contains both the CSA Welfare Retiree Fund and CSA Retiree Chapter benefits. Amazingly, I came up with almost $325,000 worth of benefits. But that number only tells part of the story.

There were several other benefit factors on the sheet that were not included in the $325,000.

1) The 20% CSA Retiree Chapter Reimbursement. Many of the Fund reimbursements also include an additional 20% of whatever the amount the Fund reimburses you. For example, if the Fund reimbursed you $500 for a home health aide, you will also receive an additional $100 seamlessly from the Retiree Chapter about 2 weeks later.

2) The Dental Program – I cannot put a monetary value on it, but obviously it is worth a lot.

3) Supplemental Medical Program – Some benefits under this program, such as Surgery/Anesthesia/Colonoscopies and Bronchoscopies, had no monetary value listed.

4) Extended Hospitalization – The city health plan provides for 365 days of hospitalization for non-Medicare members. No monetary value was given, but given the cost of hospitalization, this benefit is worth a lot of money.

And here is something else I did not take into account: some benefits reset on January 1 or after 12 months from the time they are used. Eyeglass benefits falls under this category.

Clearly, your retiree benefits from both the Fund and Retiree Chapter are extremely valuable. However, they are of little value unless you know them and use them. The document containing the benefits can be accessed from the CSA Welfare Fund website.

3. Question of the Month

Q. I am a Medicare-eligible retiree and have a $125.00 deduction taken from my pension check. What does this amount represent?

A. The $125.00 is the high option rider that you bought when you were probably active. It is your monthly premium for your GHI Enhanced Plan D. It also provides 365 days of extended hospitalization, although the CSA will pick up the cost if the member does not have the high option rider.

Informational Update Vol 14 #2 March 3, 2023

1. Medicare Part D Drug Costs - 2023

The GHI enhanced Medicare Part D drug plan in 2023 still consists of 3 stages. If you noticed a change in your prescription costs in January it may be the result of starting again in Stage I on January 1, 2023, no matter what stage you ended in on December 31, 2022. In Stage 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 $4,660 (up $230 from 2022) at some point in 2023, you enter Stage II, formerly known as the donut hole. Fortunately, the donut hole has closed for both generic and non-generic drugs; you continue to pay the same 25% of the drug cost while your plan pays 75%.

If your true out-of-pocket expense – known as TrOOP – for both Stages I & II exceed $7,400 (up $350 from 2022) you enter Stage III, or the Catastrophic Coverage. In this Stage your co-payment continues as it was in 2022: you pay 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 Stage by reimbursing you the 5% cost up to $5,000. There is no deductible. Just send your monthly 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 claim.

2. “Valentine’s Gift”

If you are Medicare eligible and have the GHI Enhanced Plan D plan, you should receive your “Valentine’s” gift of $480 for 2022 by the end of this week, depending on your mail service. The checks were mailed out on Friday, February 24.

The “Valentine’s” gift is a CSA Welfare Fund benefit designed to help defray the cost of the High Option Rider that pays for the Enhanced Plan D. If you were eligible for reimbursement, but were not on Medicare for the full year, you should receive a pro-rated check. The pro-rata is $40 a month for every month on Medicare.

Please note that 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 City 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.

3. Part B Co-Pays

In my last Update (Vol 14 #1) I mentioned that effective January 11, the judge ordered the City to stop charging retired workers the $15 co-pay for doctor visits & numerous other medical services. However, some doctors have continued to charge this co-pay because they claim the secondary insurer has not informed them to stop. It happened to me two weeks ago.

Fortunately, you can now get a new EmblemHealth Health Plan Medical Card that states there are no co-pays. When you get this card show it to your provider to ensure that you should not have to pay a co-pay

To get this card, just call 212-501-4444 and ask for a new Medical card. They may also send you an Empire Blue Cross Blue Shield card which is for hospitalization.

4. Question of the Month

Q. Since I now have to file a claim with GVS to receive an eyeglass reimbursement from the CSA Retiree Welfare Fund, do I also have to file a claim with the CSA Retiree Chapter to get its reimbursement?

A. No. Receiving the Chapter reimbursement is still a seamless operation. After GVS notifies the Chapter that your claim was approved, the Chapter will reimburse the $65. On another positive note, the eyeglass reimbursement has risen 50% to $150.

Informational Update Vol 14 #1 January 29,2023

1. 2023 Medicare Part B Deductible & Premiums

As you start to visit your Medicare doctors in 2023, you will have to pay Medicare Part B deductibles again since they reset on January 1, 2023. The deductible for Medicare Part B decreased $7 from $233 to $226. The GHI Emblem Health Medicare Part B deductible remains at $50. The part of the $226 deductible that you pay when you visit a doctor will depend on the doctor's service and what Medicare allows for the service. The likelihood is that it will be less than the full amount of the deductible. You will pay the amount that is left at future doctor visits. Remember, Medicare will not pay its part of a doctor's bill, which is about 80%, until you have fully met the deductible.

This year the standard Medicare Part B premium decreased $5.20 from $170.10 to 164.90. Although most people pay the standard premium, some pay more. For those whose Medicare Adjusted 2021 taxable income was greater than $97,000 if they filed individually or $194,000 if they filed jointly, they will pay a Part B & a Part D surcharge known as the income-related monthly adjusted amount or IRMAA in addition to the standard amount. The extra amount that they will pay varies on how much taxable income they received in 2021.

The good news is that BOTH the standard and Part B IRMAA amounts are still reimbursable. Unfortunately, the Part D IRMAA surcharge is not. While the Office of Labor Relations (OLR) reimburse the standard amount automatically, they require an application for the Part B IRMAA reimbursement. At this time, the date when the 2022 application will be available is unknown.

2. Increase & Change in Optical Reimbursement Benefit Great news!

Effective January 1, 2023, the CSA Welfare Fund optical reimbursement benefit has increased from up to $100 to up to $150. The CSA Retiree Chapter reimbursement benefit will continue at up to $65. There has also been a change in the way you file a claim for the optical benefit. No longer will you get an optical voucher from the CSA Welfare Fund. Instead, the Fund has contracted with General Vision Services (GVS) which will not only handle all of the reimbursement claims, but will offer additional comprehensive benefits as well. These generous benefits include, but are not limited to, a thorough GVS care examination, including dilation, cataract, and glaucoma screenings when required.

The CSA Welfare Fund has sent you a GVS flyer and letter that fully explains the GVS benefits and procedure for filing an optical claim. The Fund also included in the mailing a combined dental and vision ID card that validates both your GVS network and dental (SIDS/ASO) network benefits. Please note: the dental program remains the same and will function separately from the new vision benefit.

To learn more about your GVS benefits, which started January 1, 2023, go on the website, www.generalvision.com, and register for an account. To register follow these steps:

1. Click on “Register.”

2. Enter Benefit # 6025

3. Fill out the Requested Information

4. Put in a Password of your Choice.

Congratulations! You now have an account.

When you sign in, your home page will contain your name and benefit number (6025). On this page, there are links that will allow you to view your optical benefits, schedule appointments with your provider, and search for participating providers using the zip code locator.

You can also search for and register on the “GVS” App which is downloadable from the IPhone and Android App stores.

If you use a participating provider, he or she will file the claim form. You should have nothing to do other than filling in your personal information. If you are using a non-participating provider (out-ofnetwork)

- Call GVS directly at 888-346-1802 and ask for a claim form.
- Have the provider fill out his portion of the form.
- Submit the claim form to: GVS, 520 8th Ave,, New York, NY 10018

GVS will review the claim and reimburse up to $150. The CSA Retiree Chapter will receive your name and will reimburse you the additional $65.

3. $15 Co-Pay

As you probably know, the judge has ordered the City to immediately stop charging the retired city workers the $15 co-pays for doctor visits. The City plans to appeal this ruling. In the meantime, if your doctor charges the $15 co-pay (he should not if you have not yet met your deductible), pay it and keep a copy of the receipt. Hopefully, this matter will be resolved shortly.

4. Questions of the Month

Q. I am turning 65 and have health insurance through my spouse's job. Must I sign up now for Medicare Part B so I don't incur a late fee?

A. No, if your spouse's employer has 20 or more employees. Generally, Medicare will consider your health coverage credible, allowing you to delay signing up for Part B without penalty until your spouse retires.

Informational Update Vol 13 # 12 1. December 31, 2022

What is Meant by Tier Drugs? –

Your doctor prescribes you a new drug and tells you that it is a tier 3 drug. Generally, you would have no idea what the drug would cost, but knowing what tier it is lets you know if the drug is cheap or expensive.

Drug tiers are the main way drug companies inform you how much a specific drug will cost. Based on what tier the drug is in, it will have a specific co-payment.

Most of the drugs that you are prescribed are generally placed in tiers 1, 2, 3 or 4, with tier 4 drugs, known as specialty drugs, being the most expensive drugs and tier 1 drugs the cheapest.

If you are covered by the Emblem Health/GHI Enhanced Medicare Drug Plan (PDP), you recently received a letter giving you the 2023 Cost Sharing Guide for Medicare Members (click on the button below to see a copy.)

The guide gives the tier levels, type of drugs covered in those tiers, and the coverage based on whether you are in the Initial Coverage (starts January 1, 2023), Gap (formerly called the Donut Hole) Coverage, or Catastrophic Coverage categories.

Initial Coverage - the co-payment is 25% of the cost of the drug for either a 30-, 60-, or 90-day supply. The charge for insulin is $35 for a 30-day, $70 for a 60-day, or $105 for a 90-day supply. Most vaccines are free.

Gap Coverage – Formally when you were in gap coverage, you paid 75% of the drug cost. Now you pay the same 25% as in the in the Initial coverage. The charge for insulin is also $35 for a 30-day, $70 for a 60-day, or $105 for a 90-day supply.

Catastrophic Coverage - the co-payment is the greater of $4.15 or 5% of the cost for generic drugs and the greater of $10.35 or 5% of the cost of brand-name drugs. The CSA Welfare fund will also reimburse your co-pays in this category 100% up to $5,000 with no deductible.

2.TRS Income Verification Letter – RP68

Some members have called me to ask whether a letter they received from TRS requesting confirmation they are alive is legitimate. Below is the response that Mark Brodsky wrote in the last CSA Retiree Chapter Update.

TRS, on a random basis, sends out a letter asking for you to confirm that you are alive. It appears, based on the calls and emails we have received, that a significant number of these letters were recently sent out. Simply follow the instructions that TRS requests and send it back to them. You can call TRS at 888 869- 2877.

3. Catastrophe Major Medical (CMM) Plan Participation

The CMM plan purchased under NYSUT Member Benefits has had some significant changes (no changes for those who purchased CMM under AFSA or CSREA) effective January 1, 2023. These include the following:

♦ In-Network Deductible – reduced to $2,000 from current $4,000 for an individual, and $4,000 from current $5,000 for a family. The deductible is annual and out-of-pocket. Coverage is only good for a calendar year.

For example, if you meet your deductible for 2023 on July 13 and the Plan approves the 13th as the date your coverage begins, then you will be covered from July 13th through December 31st. You would have to meet the deductible in 2024 to apply for coverage again.

♦ $1,000 Critical Illness benefit. - If you are diagnosed with a critical illness on or after January 1, 2023, this benefit will provide a one-time lump sum payment of $1,000 to help defray the costs of increased medical care.

♦ Out-of-Network home health care charges – The Plan has increased the reimbursement rate from 20% to 30% of Covered Charges, I.e., the amount of remaining charge after payment by your basic plan, up to the maximum weekly and lifetime benefits when using an Out-of-Network provider for home health care

Informational Update Vol 12 #8 August 27, 2021

1. New NYC Medicare Advantage Plus Plan

As the CSARC Liaison & Outreach Coordinator for Florida, I receive many questions about member health benefits. However, this month the questions seemed endless, focusing on one specific topic: the new custom Medicare Advantage Plus Plan (MAPP).

The intent of the plan is to provide Medicare-eligible retirees equal or better medical services at a cheaper price to the city. Retirees will have a choice of either going into the new plan, which begins January 1, 2022), or remain in the Senior Care Plan. This is not an easy decision to make because of many factors, including costs and benefits of both plans.

CSA has been instrumental in providing Medicare-eligible retirees and their dependents important information about the new MAPP. As part of their continuing effort to help eligible retirees make the decision about their health plan, the CSA Retiree Welfare Fund has scheduled a

Zoom presentation given by the Alliance (Empire Blue Cross and EmblemHealth on Tuesday, August 31st at 2:00 PM.

For the first time, you, as a Medicare-eligible retiree, are going to hear directly from the group that will administer the new plan, rather than the union or the MLC. In short, from the "horse's mouth."

So I urge you to attend this Zoom presentation. To do so, you have to complete the registration form on the CSAWF website (www.csawf.org). On the home page of the website, in the left column under Event, click on Medicare Advantage Plus Plan presentation and complete the form. You will receive acknowledgment of your registration. The Zoom meeting link will be sent to the email address you provided a day before the event. If you experience any problem registering, please email your name, and the email address you wish the link to be sent to, to reservations@CSAwf.org.

2. CSA Welfare Retiree Fund & Retiree Chapter Eyeglass Benefits

Are your eyeglasses over a year old and all scratched up? If so, you might want to get new ones, especially since you would be entitled to CSA's excellent eyeglass benefits.

Optical Benefits

Every 12 months you and your spouse/significant other are entitled to be reimbursed for a new pair of glasses. The CSA Retiree Welfare Fund will reimburse you a max of $100 and the CSA Retiree Chapter will reimburse you a max of $65, for a total max of $165. The amounts are paid directly to the participant.

Procedure for Obtaining the Reimbursements

- Obtain an optical voucher. You can request the voucher from the CSA Welfare Fund website, www.CSAWF.org (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.

3. Question of the Month

Q. I am having cataract surgery and I wish to have a multi-focus lens implanted, which is not covered by Medicare. Am I entitled to a reimbursement for the lens from CSA?

A. Yes. You are entitled to $500 per eye, once in a lifetime.

Informational Update Vol 12 #7. August 3,2021

1. Customized Group Plan for Medicare-eligible Retirees

People, especially older ones, do not like change. They like when things remain the same and fear when things are different. Yet, sometimes we must be ready for change since it is unavoidable. And that's what our Medicare-eligible members must be; ready for a major change in their medical health plan.

On Wednesday, July 14, 2021, the Municipal Labor Committee (MLC) Steering Committee and the associated unions approved a new medical health plan called a Customized Group Medicare Advantage Plan for Retirees. This plan goes into effect January 1, 2022 and will replace both your traditional Medicare and your Medicare supplement (in most cases retirees have the current GHI/EBCBS Senior Care program) plans.

In a recent e-mail letter to the membership, CSA President Mark Cannizzaro and Welfare Fund Administrator Dr. Douglas V. Hathaway presented the rationale and background for implementing this new customized group Medicare Advantage plan. The letter also included a link to materials prepared by the MLC that compares the current GHI Senior Care plan and the new enhanced health plan.

Unfortunately, there has been a lot of misinformation and myths spread about the new plan, making it difficult for Medicare-eligible members to decide on whether they should stay in (on January 1, 2022 you will automatically be enrolled in the new plan) or opt-out (more information on how to opt-out will be forthcoming) of the new plan. As a result, many members have called me with myriad questions.

Below are some of the most frequently asked of those questions.

Q. Will I be able stay in the old GHI Senior Care plan?

A. Yes, however at a price. Under the new plan, there is no premium. Under the old plan, you will have an estimated non-reimbursable monthly $192.50 cost, per person, which will be deducted from your pension.

Q. Will I be able to opt-in or opt-out of the new plan?

A. Yes, during the new Annual Transfer Period. In the past, transfers were permitted only every other year. Starting January 1, 2022, transfers between plans will be permitted every year and will take place in the Fall.

Q. Will I be able to see a specialist without getting a referral?

A. Yes

Q. Will I be able to continue seeing my own doctors & go to the hospital of my own choice?

A. Yes, if the doctors and hospitals accept Medicare.

Q. Will we continue to have Part B premiums including IRMAA reimbursed, whether I join the new plan or stay with the old plan?

A. Yes

Q. Must I have a PCP?

A. No. By the way, a PCP is a primary care physician or primary care provider (also known as your family doctor) who practices general medicine. A PCP usually is the first doctor that you use for medical care.

Q. What impact does the new plan have on our Plan D coverage?

A. None. The Part D plan, which your high option rider pays for and is expected to be lower under the new plan, remains the same.

Q When will I have a co-payment under the new plan?

A. There is no co-payment for going to a PCP. However, there is a $15 co-payment for seeing a specialist, going to an Urgent Care facility, or having a diagnostic test. However, you will have the same co-payments if you stay with the old plan. Further, the max out-of-pocket cost under the new plan is $1470, while it is unlimited under the old plan.

Over the next few months, you should expect to receive much more information – either by snail mail or email - about the new plan. Please read this mail carefully. Only then will you have a better knowledge of how the new plan works and impacts your health. If you have not received any information about the new plan, please contact either the CSA Retiree Chapter or the CSA Retiree Welfare Fund.

2. Question of the Month

Q. I have an out-of-pocket expense of $1600 for eye laser surgery. Is there any reimbursement that I can receive?

A. The CSA Retiree Welfare Fund will reimburse you a once-in-a-lifetime $500.

Informational Update Vol 12 #6 June 22, 2021

1. Health Plan Premiums, Deductibles & Co-Pays

Ever been confused by the medical terms: premium, co-pay and deductible. 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.

Premium

A health plan premium is the amount that you pay to maintain your health insurance. Generally, this is paid on a monthly basis. If you are on Medicare, for example, you pay a monthly premium

for Part B. The amount depends on your taxable income and is deducted from your monthly Social Security check.

Deductible

A health plan deductible is a fixed amount that you pay for medical services or drugs (no drug deductible for Medicare-eligible members) before your health plan begins to cover medical services. For example, if you are on Original Medicare & Emblem Health, there is a $203 deductible for Medicare and a $50 deductible that starts at the beginning of the year.

Co-Pay

A co-pay is 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. Co-pays kick in after the deductibles are met. For example, if your plan says your co-pay for a drug is $10 for a 90 day supply, then every time you fill a 90 day prescription for this drug, you will pay $10.

2. Home Health Aide

One of the most frequently asked questions about CSA Retiree Welfare Fund benefits is the Home Health Aide. Home health aides are invaluable for people who become incapacitated as a result of injury or illness. The aide will assist the person take care of his/her personal needs, such as, eating, bathing, toileting, dressing, etc.

How Does the Benefit Work?

After an annual $100 deductible, the CSA Welfare Fund will reimburse you 80% of your cost up to the $10,000 annual maximum, lifetime $30,000. In addition, the CSA Retiree Chapter will reimburse you in a separate check an additional 20% of what the Fund reimburses you.

For example, if at the start of the year, you used an aide and it cost you $400, the Fund would reimburse you, after an annual $100 deductible, $240 (80% of $300). The Retiree Chapter reimburses you an additional $48 (20% of $240). Your total reimbursement would be $240 + 48 or $288. If you need an aide again during the same year, there would be no deductible so you would be reimbursed 80% of the full amount.

If you maximized the annual benefit each year that you use it, the $30,000 lifetime benefit would be depleted after 3 years. However, you can spread the use of the benefit over more than 3 years by not using up the full annual benefit. For example, suppose you collect only $5,000 of the benefit in a given year. The $5,000 left will then roll over so that you now have $25,000 left in the lifetime benefit, which will require more than 2 years to deplete since $10,000 is the annual maximum.

How do You File a Claim?

To file a claim, submit the following to the CSA Retiree Welfare Fund (nothing is needed for the CSA Retiree 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. You do not have to apply for the Chapter reimbursement.

3. Medical Coverage When Traveling Abroad

Now that we have made major strides in returning to normal, or what some might consider the new "new" normal, people are beginning to travel abroad. If you are considering traveling abroad, understand that except in some rare cases, Medicare will not cover your medical care. This is extremely important if you are considering taking a cruise that is going outside of the U.S. (Puerto Rico, the U.S, Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the U.S.) The cost for medical care on a ship is extremely expensive.

Do I have any medical coverage abroad?

Yes, you do. If you are in need of medical care abroad and Medicare is your primary coverage and Emblem Health is your secondary coverage, Emblem health now becomes your primary care. Unfortunately, your reimbursement for your medical expenses, will be relatively small. That's why, Dee Goidel, CSA Retiree Chapter Executive Board Member, wrote an outstanding article on why should purchase travel insurance when you travel outside of the U.S.

When you purchase travel insurance, it becomes your secondary coverage and Emblem Health becomes your primary coverage while you are abroad. Depending on what your travel insurance covers, it should pick up the remaining medical cost after what Emblem Health pays.

I**nformational Update Vol 12 #5 May 15, 2021**

1. 2020 IRMAA Application - The 2020 IRMAA application is now available. I have attached the application to this email. The CSA Retiree Welfare Fund also emailed a Member Update which allowed you to get the application by clicking on a link that the Update provided. Moreover, you can download the form from the CSA Welfare Fund website, www.csawf.org. IRMAA forms for the years 2017 through 2019 are also on the website as well as the corresponding differential forms.

Please make sure to include the following in your request for 2020 IRMAA:

- A completed reimbursement request application. Be sure to check off 2020 and sign and date the application. If your spouse/domestic partner is your dependent, be sure to complete the Eligible Spouse/Dependent section of the application. If your spouse/domestic partner is also a NYC retiree and has a separate NYC health plan, then she/he has to submit a separate reimbursement request application.
- The November 2019 Social Security Award letter. This is the annual letter that tells you how much Social Security you will be receiving the following year (in this case 2020) & your Medicare Part B & D premiums.
- The Social Security 1099 for 2020.

Please note that if you went on Medicare during 2020, you are entitled to a pro-rated 2020 IRMAA reimbursement.

Send the application & documents either electronically to the Doug Hathaway (dhathaway@csawf.org) or by snail mail to the CSA Retiree Welfare Fund, 40 Rector St., 12th Floor, New York, NY 10006-1729. If you would like confirmation of receipt & verification of your application and documents, then include a note and your email address in your submission.

As in the past, the CSA Retiree Fund will review your request for completeness and accuracy, and then walk it over to the City Office of Labor Relations. If there is an error in the application or in the documents you have submitted, the Fund will inform you of the exact problem so that you can correct it and re-submit the request for reimbursement.

2. CSA Welfare Fund Stop-Loss Benefit - As retired CSA members, we are quite fortunate to have outstanding CSA Retiree Fund & Retiree Chapter health benefits. Perhaps 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 all out-of-pocket medical expenses not covered by the Basic NYC Health Plan including office visits and lab charges.

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 payment. Keep in mind that Stop-Loss does not cover hospital costs.

As an example of how it works, suppose you put in a claim to the CSA Retiree Welfare Fund for a $3,000 out-of-pocket expense that falls under the stop-loss benefit. If this is your first claim for the year, you must pay an annual $1,000 deductible out of the $3,000. The Fund will then reimburse you for 80% of the next $1,250 of the claim or $1,000 and then 100% of the remaining part of the claim or $750. Your total reimbursement from the Fund for this claim is $1,000 + $750 or $1,750. About 2 weeks later, the CSA Retiree Chapter will send you a supplementary reimbursement of 20% of $1,750 or $350. Therefore your total reimbursement for the $3,000 claim is $1,750 + $350 or $2,100, and you will no longer have any future out-of-pocket expenses for any claims within the same year.

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.

Informational Update Vol 12 #4 May 1, 2021

1. What Medical Services are not Covered by Original Medicare - Original Medicare covers costs associated with doctors and hospital services that are considered medically necessary. However, it generally does not cover services that are cosmetic or alternative health treatments. Routine dental, vision and hearing services are also not covered by Original Medicare unless they are related to a medical condition. For example, routine eye exams to determine a prescription for eyeglasses is not covered. However, Original Medicare would cover an eye

exam for glaucoma. If you are in a hospital, Part A will cover emergency dental procedures and some dental services, but not dentures.

The following are additional services Original Medicare does not cover:

- Nursing home care – Includes help with daily personal care such as bathing, dressing, and using the bathroom.
- Non-medical services – Includes canceled appointments for which you are charged, private hospital rooms, and any other no-medical services.
- Routine foot care – Routine medical care for feet, such as callus removal, is not covered. However, Original Medicare will cover foot exams or treatment if it is related to a diabetes condition, or care for such foot issues as hammertoe, bunion deformities and heel spurs.
- Care in foreign countries – With few exceptions, generally not covered. However, some secondary plans, like Emblem Health, may cover the service.
- Hearing aids – Original Medicare will cover ear-related medical conditions but not hearing aids or routine hearing tests.

2. Skilled Nursing Facility – If you are on Medicare and in need of a physical therapy after an operation, you normally will be sent to a skilled nursing facility if it's needed to meet your health goal. This goal is determined by your doctor who has decided you need daily skilled care given by skilled nursing or therapy staff.

What is a 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.

What is the coverage for staying at an SNF?

- Days 1-20: $0 (covered by Medicare)
- Days 21-100: $0. (covered by Blue Cross Blue Shield)
- Days 101 and beyond: You pay all costs.

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 $2,110 of Medicare coverage for physical therapy would have been reduced by $600. Motto? Review the Medicare Summary Notices carefully.

4. Question of the Month

Q. My wife and I each received a check from the city for $1,735.20. What was that for?

A. The $1,735.20 is the reimbursement of your 2019 Medicare Part B premium. The reimbursement was based on your monthly payments of $144.60. In the past it was calculated on your monthly payments of $109, requiring you to file for the difference of what you received and were actually paid. In 2019, that is not the case; you were reimbursed for what you actually paid. You no longer will have to file for a difference since there is none

Informational Update Vol 12 #2 April 1, 2021

1. Eligibility for Home Health Care

You are in a hospital for shoulder surgery and transfer after a 3 day stay to a skilled nursing facility (SNF) for physical therapy. You now are told that you will be leaving the facility shortly, but feel you still may need physical therapy at home because it will be very difficult for you to leave the home. Will Medicare cover my home health care? Most likely yes is the simple answer.

Medicare covers a wide range of health services under its Medicare home health benefits. To be eligible for home health care, you must meet the following conditions:

- Your physical disability makes you homebound as it is extremely difficult for you to leave your home. This requirement can be met in additional ways during the pandemic. For example, your immune system is compromised and your doctor certifies that you must stay home, or you are suspected of having, or have COVID-19.
- You need skilled nursing services and/or home physical therapy care on an intermittent basis. Intermittent is defined in this context as needing a skilled nurse or physical therapy at least once every 60 days and at most once a day for up to three weeks. The physical therapy must be done by a professional or under the supervision of a professional.

- You met face-to-face with a doctor within 90 days before your home health care begins, or 30 days after the first day that you receive care. Face-to-face visits can take place in an office, hospital or by video conferencing.
- Your doctor certifies that you are homebound and need intermittent skilled care. The certification should contain a plan of care and that the face-to-face meeting requirement was met. The doctor should review and re-certify the plan every 60 day.
- Your care is given by a Medicare-certified home health agency (HHA).

If you meet all these requirements Medicare should pay for the skilled nursing care and/or physical therapy regardless of whether your condition is temporary or chronic. If you have any questions call 1-800-MEDICARE.

2. The Value of the CSA Retiree Welfare Fund and CSA Retiree Chapter Benefits

We often hear, and I often said, that our CSA Retiree Welfare Fund and CSA Retiree Fund are some of the best retiree benefits you can find anywhere. But how good are they really? To answer that question I decided to see if I can put a monetary value on our benefits. So one day I added all the monies that were listed on the document that contains the Retiree Fund and Retiree Chapter benefits. Amazingly, I came up with almost $325,000 worth of benefits. But that number only tells part of the story.

There were several other benefit factors on the sheet that were not included in the $325,000.

1) The 20% CSA Retiree Chapter Reimbursement. Many of the Fund reimbursements also include an additional 20% of whatever the amount the Fund reimburses you. For example, if the Fund reimbursed you $500 for a home health aide, you will also receive an additional $100 seamlessly from the Retiree Chapter about 2 weeks later.

2) The Dental Program – I cannot put a monetary value on it, but obviously it is worth a lot.

3) Supplemental Medical Program – Some of the benefits under this program, such as Surgery/Anesthesia/Colonoscopies and Bronchoscopies, had no monetary value listed.

4) Extended Hospitalization – The city health plan provides for 365 days of hospitalization for non-Medicare members. No monetary value was given, but given the cost of hospitalization, this benefit is worth a lot of money.

And here is something else I did not take into account: some of the benefits reset on January 1 or after 12 months from the time they are used. Eyeglass benefits falls under this category.

Clearly, your retiree benefits from both the Fund and Retiree Chapter are extremely valuable. However, they are of little value unless you know them and use them. The document containing the benefits can be accessed from the CSA Welfare Fund website.

3. Question of the Month

Q. I am a Medicare-eligible retiree and have a $142.50 deduction taken from my pension check. What does this amount represent?

A. The $142.50 is the high option rider that you bought when you were probably active. It is your monthly premium for your GHI Enhanced Plan D. It also provides 365 days of extended hospitalization, although the CSA will pick up the cost if the member does not have the high option rider.

Informational Update Vol 12 # March 1, 2021

1. Medicare Part D Drug Costs

The GHI enhanced Medicare Part D drug plan consists of 3 stages. If you noticed a change in your prescription costs in January it may be the result of starting again in Stage I on January 1, 2021, no matter what stage you ended in on December 31, 2020. In Stage 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 $4,130 (up from $4020 in 2020) at some point in 2021, you enter Stage II, formally known as the donut hole. Fortunately, the donut hole has closed for both generic and non-generic drugs; you continue to pay the same 25% of the drug cost while your plan pays 75%

If your true-out-of-pocket expense – known as TROOP – for both Stages I & II exceed $6,550 (up from $6,350 in 2020) you enter Stage III, or the Catastrophic Coverage. In this Stage your co-payment continues as it was in 2020 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 Stage 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. "Valentine's Gift"

If you are Medicare eligible and have the GHI Enhanced Plan D plan, you should have received your "Valentine's" gift of $480 for 2020 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. If you were eligible for reimbursement, but were not on Medicare for the full year, should have received a pro-rated check. The pro-rata is $40 a month for every month on Medicare.

If you have not yet received your check, wait a little longer before calling the Welfare Fund as there may have been a delay in the mail.

Please note that 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 City 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.

3. Acupuncture

Medicare covers acupuncture for 12 visits within 90 days for chronic lower back pain. If the Medicare-eligible patient shows improvement, he or she may get an additional 8 visits for an annual maximum of 20 visits.

Chronic lower back pain is defined as:

· Lasting 12 weeks of longer

· Having no known cause (no relation to cancer that has spread, inflammatory or infectious disease)

· Pain not associated with surgery of pregnancy

Only a doctor, or a health care provider, such as a nurse practitioner or physician assistant, may administer acupuncture providing they have:

- A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine
- A current, full, active, and unrestricted license to practice acupuncture in the state where the acupuncture is being given

The CSA Retiree Welfare Fund also has an acupuncture benefit under its Supplemental Medical Program that you may use after you have exhausted your Medicare Acupuncture benefit, or directly, if you are not Medicare-eligible.

Acupuncture Benefit

After an annual $100 deductible, you get back 80% of the cost for 36 visits per year. The maximum allowable charge is $100 per visit. In addition, the CSA Retiree Chapter will reimburse you an additional 20% of the Fund reimbursement.

Consequently, the maximum reimbursement you can get for 36 visits costing $100 per visit is calculated as follows:

a) The 1st visit costing $100 covers your deductible.

b) The next 35 visits cost @ $100 per visit $3,500.

c) The CSA Retiree Welfare Fund will reimburse you $3,500 x 80% or $2,800.

d) The CSA Retiree Chapter will reimburse you seamlessly $2,800 x 20% or $560.

e) The total reimbursement is $2,800 + $560 = $3,360

Informational Update Vol 12 #1 February 1, 2021

Here is some important information:

1. 2021 Medicare Part B Deductible & Premiums

As you start to visit your Medicare doctors in 2021, you will have to pay deductibles again since they reset January 1, 2021. The deductible for Medicare increased $5.00 from $198 to $203. (GHI remains at $50). The portion of the $203 deductible that you pay when you visit a doctor will depend on the doctor's service and what Medicare allows for the service. The likelihood is that it will be less than the full amount of the deductible. You will pay the amount that is left at a future doctor visit or visits. Remember, Medicare will not pay its portion of a doctor's bill, which is about 80%, until you have fully met the deductible.

This year the standard Medicare Part B premium increased $3.90 from $144.60 to $148.50. But some people who enrolled in Medicare in 2020 or earlier will pay slightly less (about $145 per month) because of a hold harmless provision that doesn't allow Social Security payments to be reduced from year to year for Medicare premiums.

If your monthly 2019 taxable income was greater than $88,000 if you filed individually or $176,000 if you filed jointly, you will also pay a surcharge known as the income-related monthly adjusted amount or IRMAA in addition to the standard Medicare Part B premium.

The good news is that BOTH the 2021 standard and IRMAA amounts are still reimbursable. The Office of Labor Relations (OLR) should reimburse you the standard amount automatically in October '22, however, you must apply for the IRMAA reimbursement. The application should become available in January 2022 or February 2022 at the end of 2021. However, you will be able to apply for 2020 IRMAA shortly.

How do You Apply for 2020 IRMAA

If you are eligible for 2020 IRMAA reimbursement, the application will become available in the next several weeks on the CSA Welfare Fund website, www.csawf.org. When you get the application, you must check which year you are applying for reimbursement. (You can apply separately for 2017 or 2018 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.

How do I Know if I am Eligible for 2020 IRMAA?

There are 2 ways to determine 2020 IRMAA eligibility:

- Your 2020 Part B premium was greater than $144.60.
- Your 2018 taxable income (2020 Part B premium was based on this amount) was greater than $85,000 if you filed individually or $170,000 if you filed jointly.

Documents Needed to Submit Along 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 2019, indicating how much your Medicare Part B premium was going to be in 2020. (Do not confuse this letter with the one you received this past November, which indicated your 2021 Medicare Part B premium. Put that away in a safe place.

2) The SSA-1099 letter you should have received in January 2021, 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.

Where Should I Send the Completed IRMAA Application & Documents?

Send your completed application to the CSA Welfare Fund, 40 Rector St, 12th Floor, New York, NY 10006. 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.

When Will I Receive My IRMAA Reimbursement?

If all goes well, you should receive it in October 2021

Reminders:

1) Do not submit original documents. Only copies.

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

2. Question of the month

Q. Is a Medicare-eligible member covered for emergency ambulance service to the hospital?

A. Medicare plus the secondary insurance overs ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health.

Informational Update Vol 11 # 11 December 29, 2020

1. 2021 Social Security Letter – If you are eligible for Medicare, you should have received a letter from Social Security (known as the SSA letter) in late November indicating your 2021 Social Security benefit amount before and after deductions (please keep in a safe place). The benefit amount was based on the following: 1) your 2019 taxable income 2) a 1.3 percent COLA increase before deductions, 3) the deduction for Medicare Part B standard amount (in 2021, the amount is $148.60, an INCREASE of $4.10 from 2020), and 4) the deductions for IRMAA for Medicare Parts B & D.

The Income-Related Monthly Adjustment Amount (IRMAA) is a surcharge that is deducted ONLY from those Medicare-eligible members whose taxable income surpasses a certain amount. In 2021, this income-threshold is $88,000 if you filed individually (up $1,000 from 2020) and $176,000 if you filed jointly (up $2,000 from 2020) if you filed jointly. The amount of the deductions for IRMAA Parts B & D can be determined from the taxable income chart that is included in the letter.

Please note: If you do not receive a social security check and are Medicare-eligible, Medicare will bill you for Medicare Part B premiums (& Part D if your Part B premiums include an IRMAA surcharge) once every quarter. However, you can sign up for direct payments by contacting SSA at the number provided at the back of your quarterly invoice.

The good news regarding the Medicare Part B premiums is that they are reimbursable. You will receive the standard amount automatically; you must apply for the IRMAA reimbursement. In 2021, for example, you should receive your 2020 standard reimbursement automatically in April 2021. You will have to apply for 2020 Part B IRMAA. The application should be available sometime in January 2021. Once it is available, you can download it from the CSA Welfare Fund website, www.csawf.org.

I suggest you complete and submit the 2020 Part B IRMAA application as soon as you can to ensure that you will receive the reimbursement according to schedule, which should be around the middle of October 2021. Please note that Part D IRMAA is NOT reimbursable.

2. What is Meant by Tier Drugs? – Your doctor prescribes you a new drug and tells you that it is a tier 3 drug. Generally, you would have no idea what the drug would cost, but knowing what tier it is lets you know if the drug is cheap or expensive

Drug tiers are the main way drug companies inform you how much a specific drug will cost. Based on what tier the drug is in, it will have a specific co-payment.

Most of the drugs that you are prescribed are generally placed in tiers 1, 2, 3 or 4, with tier 4 drugs, known as specialty drugs, being the most expensive drugs and tier 1 drugs the cheapest.

If you are covered by GHI Enhanced (PDP) Group for drugs, you recently received a letter giving you the 2021 drug cost sharing guide for Medicare members. The guide gives the tier levels, type of drugs in those tiers and the coverage based on whether you are in the Initial Coverage (starts January 1, 2021), Gap Coverage or Catastrophic Coverage categories.

For each tier in the Initial Coverage, the co-payment is 25% of the cost of the drug for a 30, 60, or 90 day supply, except for tier 4, where a 60 or 90 supply is unavailable. The same 25% co-payment applies in the Gap Coverage. In the Catastrophic Coverage, the co-payment is the greater of $3.70 or 5% of the cost for generic drugs and the greater of $9.20 or 5% of the cost of brand-name drugs.

3. Question of the Month

Q. I did not receive my SSA letter listing my 2021 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.

1. 2019 IRMAA Differential Reimbursement

On November 13, 2020, the Office of Labor Relations (OLR) issued IRMAA 2019 Differential reimbursements. The amount was $318 for each IRMAA-eligible member (providing he/she applied for IRMAA) and their Medicare-eligible dependent spouse/legal partner who went on Medicare prior to 2016. For those Medicare-eligible members who are not eligible for IRMAA reimbursement, but also went on Medicare prior to 2016, OLR is scheduled to issue the differential payment sometime during March 2021. However, you need to submit a 2019 Differential Reimbursement application in order to receive the differential reimbursement.

Keep in mind that it is not too late to submit a 2019 IRMAA application or a 2019 Differential application. You can down an applications for 2019, as well as 2017 and 2018, from the CSA Welfare Fund website, www.csawf.org.

Although the application instructs you to submit it to the NYC Office of Labor Relations, do not do so since that office is closed. Instead, send the application along with the proper documentation to the CSA Welfare Fund, 40 Rector St., 12th Floor, New York, NY 10006.

2. Fall 2020 Transfer Period vs. the Open Enrollment Period

You may have received a letter a few days ago announcing the Fall 2020 Transfer Period. The question is what is it and how does it differ from the Open Enrollment Period.

Open Enrollment Period

As I wrote last month, The Open Enrollment Period is that period which enables you to switch from Original Medicare (which most Medicare-eligible members have) to a Medicare Advantage Plan, a Medicare Advantage Plan to Original Medicare or one Medicare Advantage Plan to another Medicare Advantage Plan. This period runs from October 15, 2020 to December 7, 2020.

Fall 2020 Retiree Transfer Period

The Fall 2020 Retiree Transfer Period is that period when non-Medicare-eligible members can change their medical plan and Medicare-eligible members can change their supplementary medical plan to another health plan, respectively, under the NYC Health Benefits Program. The period runs from November 1, 2020 through November 30, 2020. The above-mentioned letter contains the contact information of the city health plans.

I cannot recommend whether you should change plans. That is a personal decision. What I can tell you is that most people do not change health plans. However, if you choose to do so, I strongly suggest you first contact Doug Hathaway for his input before completing the application that was attached to the letter.

3. Medicare Expands Coverage Under Medicare

Medicare covers many kidney dialysis services and supplies if you suffer from End-Stage-Renal Disease (ESRC) including outpatient dialysis treatments & doctor services. The treatments can take place in a Medicare-certified dialysis facility or your home. Starting in January, Medicare is expanding its coverage to make it easier for patients to get the dialysis treatments at home.

The government expects that 1 in 3 Medicare patients dealing with ESRC will be enrolled in a program that will "reward more convenient, comfortable options like home dialysis." The purpose of the program is to curtail exposure for ESRD patients to COVID-19 by eliminating the need to go to a dialysis clinic.

4. Question of the Month

Q. I was transferred from the hospital to a skilled nursing facility for rehabilitation. Am I covered?

A. Medicare covers you for the first 20 days. After that, your Blue Cross, Blue Shield covers you for the next 80 days. Total coverage is 100 days.

Informational Update Vol. 11 #9 October 27, 2020

1. 2019 Medicare Part B Differential Reimbursement.

In April 2020, the NYC Office of Labor Relations automatically (no application necessary) reimbursed both you, as a CSA Medicare retiree, and your Medicare eligible dependent spouse/legal partner the 2019 Medicare Part B standard premium. If you went on Medicare prior to 2016, the amount of the reimbursement ($1,308) was based on a monthly payment of $109. However, you most likely paid $135.50 and, therefore, are still owed ($135.50 - $109) x 12 or $318. This amount is known as the Differential Reimbursement. If you went on Medicare after 2016, you received the correct amount of $1,626 ($135.50 x 12) and are not owed a differential reimbursement.

On October 16, 2020, you and your Medicare-eligible spouse/legal partner should have received your 2019 IRMAA Reimbursement Form providing you were eligible for IRMAA reimbursement and filed an application in a timely fashion. (Unfortunately, many eligible members received the wrong amount – more on this later) 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.

If you are eligible for 2019 IRMAA reimbursement but have NOT yet applied, you can still do so. Just submit a completed 2019 IRMAA form to the CSA Welfare Fund Office, 40 Rector St., 12th Floor, New York, N.Y. 10006. You can download the form from the CSA Welfare Fund website, www.csawf.org. Be sure to include with the form a copy of the November 2018 SSA and 2019 SSA-1099 letters 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 2019 IRMAA Reimbursement?

You are eligible for 2019 IRMAA reimbursement if your Nov'18 SSA letter, which indicated your monthly 2019 Medicare Part B premium, was GREATER than $135.50. If you cannot find that letter, look at the SSA-1099 letter you received in January'20. If the amount was GREATER than $1626, you are eligible. Finally, if you cannot find either document, look at your taxable income for 2017, the year in which your 2019 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. However, you will need to get copies of the above-mentioned letters since they must be included with your IRMAA application. These letters can be obtained either by calling your local SSA office or downloaded from the SSA website (you must have an account or open an account), www.SSA.gov.

How Do I Collect the Differential Reimbursement If I Am Not Eligible For 2019 IRMAA?

If you and your Medicare-eligible dependent spouse/legal partner are NOT eligible for 2019 IRMAA reimbursement but paid $135.50 monthly for Medicare Part B, you need to complete a 2019 Reimbursement Differential Request form 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 2019 SSA-1099 SSA letter 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.

When Will I Receive the Differential Reimbursement?

If you applied for the Differential reimbursement because you were not eligible for IRMAA, you should receive the reimbursement in March'21. If you were eligible for IRMAA and filed an application, you DO NOT have to file a Reimbursement Differential Request form. You will receive the Differential reimbursement automatically. The expected date is November'20.

2. Medicare Advantage Plans

I am sure you have received by now 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 glass coverage, hearing exams 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, 2020 to Dec 7, 2020. During this period, a Medicare-eligible person can switch from Original Medicare to a Medicare Advantage Plan, Medicare Advantage Plan to Original Medicare or one Medicare Advantage Plan to another Medicare Advantage Plan.

Should I Switch 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 along 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. Also, Medicare Advantage plans generally have copayments. Although, Original Medicare may have a larger premium than some plans, it is reimbursable. If you join a Medicare Advantage Plan, you are no longer eligible for a Part B Medicare premium reimbursement.

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

3. Question of the Month

Q. I am Medicare-eligible member whose 2019 IRMAA reimbursement was much too high. Why did that happen?

A. As you know, we have been experiencing a terrible pandemic that had required a shutdown of virtually all non-essential offices in mid-March. This included the Office of Labor Relations (OLR) as well as CSA. Although the CSA offices have opened on a limited basis, OLR has been operating its office remotely. As a result, OLR was unable to process all the IRMAA applications they received either directly or by the CSA Welfare Fund in time for the October reimbursement. OLR decided to reimburse those members whose applications were not processed at the same level they were reimbursed in 2018. (There are 5 levels of IRMAA payments. In 2018 they ranged from $54.10 to $325, depending on your taxable income.) For example, if a member was reimbursed at the 1st level in 2018, he was reimbursed at the same level for 2019.

In your case, OLR probably had not processed your application and, consequently, you received the same reimbursement level for 2019 that you had received in 2018. However, if your 2019 level is less than your 2018 level, you were most likely overpaid. OLR has indicated this overpayment will be deducted in 2020 IRMAA reimbursement.

There were also some eligible members who received a 2019 IRMAA reimbursement without ever filing a 2019 IRMAA Reimbursement Form. The reimbursement was based on their 2018 reimbursement leveI. If you fall in this category, you must submit a 2019 IRMAA Reimbursement Form.

Informational Update Vol 11 #8 September 16, 2020

1. Medicare Covers Acupuncture for Back Pain for 2021

Effective January 1, 2021, Medicare will cover up to 12 acupuncture visits in a 90 day period for chronic lower back pain providing:

- The pain is lasting 12 weeks or longer
- The pain is not related to spreading cancer, inflammatory or infectious disease
- The pain is not associated with pregnancy or surgery

Medicare will also cover an extra 8 sessions if your doctor indicates that your chronic back pain shows improvement. If the doctor indicates there is no improvement or your condition is getting worse, then Medicare will not cover the additional sessions. Medicare covers no more than 20 treatments yearly. These treatments may only be used for chronic lower back pain.

Once you have exhausted your allotted 20 treatments, you can turn to the CSA Retiree Welfare Fund and CSA Retiree Chapter for additional coverage.

- CSA Retiree Welfare Fund – You are allowed a maximum of 36 visits a year. The maximum allowable charge is $100 per visit. After an annual $100 deductible you will be reimbursed 80% of the cost.
- CSA Retiree Chapter – You will get an additional 20% reimbursement of whatever the Fund reimburses you. You do not have to apply for it as the process is a seamless operation. The reimbursement should come about 2 weeks after the Fund reimbursement.

2. Change in Prescription Drug Benefit

One of the most important features under the Affordable Care Act (ACA) is the requirement that health plans cover certain medications & supplements that are considered preventative at no cost to eligible people. From the outset of ACA, the U.S. Preventive Services Task Force (USPSTF) determined the list of drugs, both prescription and over-the-counter (OTC), that fall under this category. The list, which is quite extensive, includes such drugs as Tamiflu, contraceptives, pre-natal vitamins and statins.

Effective July 1, 2020, your health plan covered at no cost to you one specific dosage of Truvada – 200-300 milligrams – since it was now considered a Pre-Exposure Prophylactic medication (PreP), which is a preventative for people who are very high risk of getting HIV. No longer do you need to get the drug through the Welfare Fund.

If you are not on Medicare, there will be no copay. If you are Medicare-eligible, you will continue to pay the 25% copay.

3. Flu Vaccine

With the 2020 flu season quickly approaching, you need to take your flu shot. Taking the shot this year is especially important as the public health officials continue to grapple with the COVID-19 pandemic. While the flu is not as dangerous as coronavirus, it does kill thousands of people each year. Amazingly, only 45% of Americans were vaccinated last year.

Not everyone can get the flu shot for medical reasons; everyone should consult with their doctor before taking the shot.

Keep in mind that vaccinated people cuts down on the transmission of the flu from one person to another, creating a type of herd immunity.

4. Question of the Month

Q. I am the spouse of a retired CSA member and just paid a $300 deductible for a recent hospitalization. Is there coverage for the $300?

A. Hope you are feeling well…Yes, there is. Submit the invoice and proof of payment to the CSA Retiree Welfare Fund. After an annual $100 deductible under the Fund's Supplemental Medical Program, you will get back 80% of $200 ($300-$100) or $160. Moreover, the CSA Retiree Chapter will reimburse you seamlessly (you do not have to apply) an additional 20% of $160 or $32. Total reimbursement: $192.

Informational Update Vol 11 #7 August 25, 2020

1. **Contact Tracing**

It is hard to believe, but almost ½ year has passed since the country closed down because of the coronavirus. Our lives since have changed dramatically in many ways. One of those ways has been new words and terms added to our everyday vocabulary, such as contact tracing.

What is contact tracing? According to Webster's dictionary, contact tracing is "the practice of identifying and monitoring individuals who may have had contact with an infectious person as a means of controlling the spread of a communicable disease. " Contact tracers are like detectives in their attempt to find all the people who might have been in contact with someone who tested positive for COVID-19. Their purpose is to try to slow down the spread of the disease.

If you have been in close contact with someone who has tested positive for COVID-19, a contact tracer or public health worker may call you.

If that happens, be aware of the following:

· You will be told that you may have been exposed to someone with COVID-19. The caller will ask who you have been in contact with and your recent whereabouts. You should answer those questions as all the information you give, including your name, is strictly confidential and may help stem the spread of the disease. The caller's only interest is to track down all people who have been in contact with a person who tested positive for COVID-19 and warn them of their possible exposure.

· You may be asked to self-quarantine for 14 days. This means you stay home, maintain social distancing from all those in the household, and monitor your health.

· You may be asked to watch for symptoms of COVID-19. Let your doctor know if you get symptoms and, if your condition gets worse, get medical help.

Of course, you always have to watch out for COVID-19 scammers. A legitimate tracer or health worker will never ask you for:

§ Money

§ Your Social Security Number

§ Bank Account Information

§ Salary Information

§ Credit Card Numbers

If someone asks for this information, hang up immediately, and report it to Medicare at 1-800-MEDICARE.

2. Medicare/Emblem Health Glitch

Over the past several days, I have gotten calls concerning a glitch in the way Medicare/EmblemHealth are handling claims.

Background

In June 2020, EmblemHealth issued a new medical card that had a new ID medical number. The card went into effect July 1, 2020. Your job was to give your doctors the new ID card when you first visited their offices after July 1st.

The Problem

There is apparently a breakdown in the way Medicare and EmblemHealth communicate with each other regarding the new EmblemHealth medical card.

In the past, doctors would send a request for payment for services rendered to a Medicare eligible member directly to Medicare. After Medicare would determine what portion of the payment was allowable and pay about 80% of that portion, it would then send the request for payment to EmblemHealth (or whoever was the secondary provider) to pay the remaining portion, which is about 20% of the request.

This process worked well for years. Somehow, it broke down after the new cards went into effect. Medicare, instead of sending the request to EmblemHealth, sent it to Blue Cross, Blue Shield. Because this provider handles hospital claims, it obviously did not cover the remaining amount of the doctor's request for payment.

This problem is systemic as it has affected many retired CSA Medicare-eligible members. CSA Retiree Welfare Fund Administrator Doug Hathaway has been in contact with Medicare and EmblemHealth, and was informed that they are aware of the problem and are working on correcting it.

Understand, CSA did not cause this problem. This is strictly a matter for Medicare/EmblemHealth to resolve. Doug will continue to monitor the situation until that happens to everybody's satisfaction.

What should I do now?

If you haven't already done so, give your doctors your new EmblemHealth Medical cards so they can record your new Medical ID number.

If you are experiencing above-mentioned problem, call Medicare and EmblemHealth to inform them of your situation. The more people call, the more pressure these two organizations will feel to resolve the problem as quickly as possible.

Do I have to pay the amount the claim says I owe?

No! All you received is a claim, not a bill. Should you get an actual bill, contact the CSA Retiree Welfare Fund or CSA Retiree Chapter.

3. Question of the Month

Q. I am a retired 85 year old retired CSA supervisor. TRS sent me a letter asking me if I am still alive. Is this some sort of scam?

A. No! TRS has been asking this question of our very elderly retired CSA supervisors. Answer the letter. If you don't, TRS might stop your pension, and it could take up to 4 months for it to resume. If you cannot get your response notarized as instructed, TRS will accept your family doctor's verification.

Informational Update Vol 11 #6 July 27, 2020

1. Medical Conditions and COVID-19

As you probably are aware, people of any age, but especially senior citizens, who are seriously compromised with certain medical conditions, such as heart disease, diabetes or chronic obstructive pulmonary disease (COPD), are very susceptible to getting the COVID-19 disease.

Medicare strongly recommends that if you have increased risk to COVID-19, you must take certain protections. These are some of them:

· Do not forget to take your medicines and treatment plans as directed by your doctor.

· If you are not feeling well, CALL your doctor. Do not delay in getting emergency medical attention if it becomes necessary.

· If you must go out in public, wear a mask and keep socially distanced.

Keep in mind that Medicare covers the following related to COVID-19:

§ Telehealth and virtual visits as long as it isn't related to a medical visit within the previous 7 days or doesn't lead to a medical visit in the next 24 hours (or soonest appointment available).

§ COVID-19 Lab tests.

§ FDA-authorized COVID-19 antibody tests if you had, or were suspected of having, COVID-19.

§ COVID-19 hospitalizations. This includes if you were ready to be discharged from a hospital but need to stay because you contracted COVID-19.

§ Although there is no approved vaccine, it will be covered when it becomes available.

COVID-19 has provided a whole new fertile ground for scammers. Because people, especially those at risk, can be distracted by the disease, scammers have jumped in to try to get your personal information. As always, guard your Medicare card and check your Medicare Claims Summary forms for errors or possible fraud. Do not respond to anyone who alleges there is something wrong with your Medicare card and needs certain information. Just, hang up. Remember, Medicare does not call, they write.

2. Home Health Aide

One of the most frequently used CSA Retiree Welfare Fund benefits is the Home Health Aide. Home health aides are invaluable for people who become incapacitated as a result of injury or illness. The aide will assist the person take care of his/her personal needs, such as, eating, bathing, toileting, dressing, etc.

How Does the Benefit Work?

After an annual $100 deductible, the CSA Welfare Fund will reimburse you 80% of your cost up to the $10,000 annual maximum, lifetime $30,000. In addition, the CSA Retiree Chapter will reimburse you in a separate check an additional 20% of what the Fund reimburses you.

For example, if at the start of the year, you used an aide and it cost you $300, the Fund would reimburse you, after a $100 deductible, $160 (80% of $200). The Retiree Chapter would then give an additional $32 (20% of $160). Your total reimbursement would be $160 + $32 or $192. If you needed an aide again during the same year, there would be no deductible so you would be reimbursed 80% of the full amount.

If you maximized the annual benefit each year that you use it, the $30,000 lifetime benefit would be depleted after 3 years. However, you can spread the use of the benefit over more than 3 years by not using up the full annual benefit. For example, suppose you collect only $5,000 of the benefit in a given year. The $5,000 left will then roll over so that you now have $25,000 left in the lifetime benefit, which will require more than 2 years to deplete.

How do You File a Claim?

To file a claim, submit the following to the CSA Retiree Welfare Fund (nothing is needed for the CSA Retiree 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.

3. Question of the Month

Q. I am a retired CSA supervisor and just went on Medicare. Are the cost of drugs still reimbursable?

A. Unfortunately, they no longer are reimbursable until your out-of-pocket drug expenses reach $6,350. 80% of all drug expenses beyond that amount are reimbursable with a maximum reimbursement of $5,000

Informational Update Vol 11 #4 May 29, 2020

1. "No RMD Payment in 2020"

Recently, the Teachers' Retirement System sent a letter to retired members who were eligible to receive Required Minimum Distributions (RMD) from their Tax-Deferred Annuity (TDA) Program account in 2020. The letter stated that as a result of recent federal legislation, known as the CARES Act, RMD's for 2020 were being suspended, and the amount that you were entitled to

was not eligible for direct rollover. To emphasize this, the words, “NO RMD PAYMENT IN 2020,” were typed in bold in the upper right-hand corner of the letter.

Almost immediately upon receiving the letter, our members started calling me with myriad questions. They were excellent questions that I thought I should share the answers to in this article. But before I do, a little background…

On Friday, December 20, 2019, the federal government signed into law, effective January 1, 2020, the Setting Every Community Up for Retirement Enhancement Act (Secure Act). This law made drastic changes to long-term retirement savings and affected all Americans at every age.

Prior to the law, you needed to take an RMD in the year you turned 70½. Now, under the Secure Act, that number changed to 72 if you did not reach 70½ before January 1, 2020.

However, under the Cares Act, RMD’s were suspended for 2020.

As a result, your TDA has another year (as of now, RMD’s will take place in 2021) to recoup losses due to a downturn in the stock market. The law also gives you a tax break of not being taxed on a mandatory withdrawal, or being put into a higher tax-bracket.

I can say much more about RMD’s and the two laws mentioned above, but before I run out of space, let’s turn to the questions.

1) Q: What is meant by a direct rollover?

A: A direct rollover is an electronic transfer of your retirement funds from one retirement account (e.g., your TDA) into another qualified account (such as an IRA). Generally, you can do that with your TDA Funds at any time. However, your RMD, as indicated in the letter, is not eligible for a direct rollover.

2) Q: Can I still withdraw my RMD?

A. Yes, however, you will have to pay taxes on the RMD that may put you in a higher tax bracket. Further, if your TDA is in fixed, it gets 8¼% interest. If you really need your RMD for expenses, you might be better off taking the money out from another source if you can, and not lose such high interest.

3) Q: Will I pay double RMD in 2021?

A: No. Your 2021 RMD will be based on the amount of your TDA as of December 31, 2020.

4) Q: Will the 2020 RMD continue to get interest if I do not withdraw it from my fixed TDA account?

A: Yes.

2. Exceptions to Signing Up for Medicare When Turning 65

Last month I wrote about having to sign up for Medicare when you enter your enrollment period as you turn 65. If you don't, you face a 10% increase in your Part B premiums for every year you're eligible but don't enroll, unless you happen to qualify for an exception. This article is about some of those exceptions.

You are 65 and still working

You do not need to sign up for Medicare if you have coverage under a group health plan through an employer who has a minimum of 20 employees. If the employer has fewer than 20 employees, you need to sign up for Medicare Parts A & B, which then becomes your primary health insurance.

You are 65 and your spouse is working

You do not need to sign up for Medicare if your spouse has coverage under a group health plan through an employer who has a minimum of 20 employees (if fewer, need to sign up) and your wife's plan covers you.

Though you do not need to apply for Medicare if you fall in either of the two categories, it would be advantageous for you to apply for Medicare Part A since it won't cost you anything and it will become your secondary insurance. If and when you lose the employer's health plan coverage, you will get an eight month special enrollment period to sign up for Medicare. This period will start the month after you lose the coverage.

3. Question of the Month –

Q. On April 17, I received a Part B standard amount check for $1,626. Am I eligible for the 2019 differential?

A. No, you received the full reimbursement. If you went on Medicare after January 1, 2016, your reimbursement was based on a monthly premium of $135.50 and you received the full reimbursement. However, those members who went on Medicare prior to that date, had their reimbursement based on a monthly premium of $109.30. This group received $1,308. Those members who are eligible for IRMAA reimbursement, will have the difference included in their IRMAA checks, providing they apply for IRMAA. Those who are not eligible will have to apply for the difference using the differential application that can be downloaded from the CSA Welfare Fund website, www.csawf.org.

Informational Update Vol 11 #3 May 1, 2020

As the COVID-19 pandemic continues to wreak havoc throughout the world, I hope this update finds you well and safe…Here is some important information…

1. 2019 Medicare Part B Reimbursement

You should have automatically (no application necessary) received the 2019 standard Medicare Part B reimbursement on April 17, 2020. If you have direct-deposit, the check was either directly deposited in the same bank account as your pension, or, if you do not use direct deposit, mailed to your home. This payment is separate from your pension payment.

If you went on Medicare Part B prior to January 1, 2016, you received $1,308 for the full year ($109 monthly). However, you paid $135.50 per month or $1,626 for the full year. Consequently, you are entitled to an additional Part B reimbursement, known as the Part B Reimbursement Differential. The amount of the reimbursement is $318 (($135.50-$109) x 12) for which you have to apply.

If you enrolled during the calendar year 2016 or later, you received the correct amount of $135.50 per month or $1,626 for the full year (pro-rated if you were not on 2019 Medicare for the full year) and need not take further action.

How to Apply for the Medicare Part B Differential Reimbursement

If you are eligible for 2019 IRMAA (monthly Part B premium was more than $135.50 in 2019) and have filed for 2019 IRMAA, DO NOTHING. Your IRMAA reimbursement scheduled for October 2020 should automatically include the differential. If you have not yet filed for 2019 IRMAA please do so NOW by filling out the 2019 IRMAA application (application can be downloaded from the CSA Welfare Fund website, www.csawf.org) and submit it along with the required documents to the CSA Retiree Welfare Fund, which will verify the correctness of your application & documents

2) If you DID NOT QUALIFY FOR 2019 IRMAA, you must complete the Reimbursement Differential form and submit it along with the required document to the CSA Retiree Welfare Fund.

Required Documents

· 2019 SSA – 1099 if you are ON Social Security

· Other proof of payment such as CMS-500 Notice of Medicare Payment or bank statements if you are NOT on Social Security

Please note your spouse/domestic partner/Medicare-eligible dependent is entitled to these reimbursements as well.

2. Signing Up for Medicare

I often receive calls from members approaching Medicare eligibility – 65 years of age - about how to sign up for Medicare. Generally, the conversation lasts a few minutes because the explanation takes almost no time.

§ If you are ON social security, you are automatically enrolled in Medicare Part A & B effective the month you turn 65. Social Security will send you a Medicare card and an informational letter about 3 months before your 65th birthday. If you do not get the letter, call the Social Security Administration (SSA) at 1-800-772-1213 or, if you prefer, visit your local Social Security office.

§ If you are NOT on Social Security, you will have to sign up for Medicare by calling SSA or visiting your local SSA office. You can also sign up online at www.socialsecurity.gov/medicareonly/. If you don't sign up for Medicare during your initial enrollment period, which begins 3 months before the month of 65th birthday and continues until 3 months after that birthday, you face a 10% increase in your Part B premiums for every year you're eligible but don't enroll, unless you happen to qualify for an exception (I will discuss exceptions in future updates).

When you go on Medicare, you will have to pay a premium for Medicare Part B, which the Office of Labor Relations (OLR) will reimburse you. To be able to do that, OLR will require a copy of your Medicare card. The CSA Welfare Fund makes that requirement easy for you to carry out. Just mail a copy of the Medicare card to the CSA Welfare Fund, 40 Rector St., 12th floor. New York, NY 10006. The Fund will send a copy to OLR. They will also send a copy to your Medicare supplemental health plan (Part B pays about 80% of the cost, the supplemental plan pays the rest) to notify them of the changes in your health coverage. You are now set.

3. Question of the Month

Q. How do I know I am eligible for 2019 IRMAA reimbursement?

A. There are several ways, but perhaps the simplest one is to look at your 2019 SSA-1099 letter which you need to file your 2019 tax return. If that amount is greater than $1,626, you ARE eligible and need to file a 2019 IRMAA application.

Informational Update V 11 #2 dated March 21, 2020

1. Medicare Part D Drug Costs

The GHI enhanced Medicare Part D drug plan consists of Tier I. II & III. If you noticed a change in your prescription costs in January it may be the result of starting again in Tier I on January 1, 2020, no matter what tier you ended in on December 31, 2019. 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 $4,020 (up from $3820 in 2019) at some point in 2020, you enter Tier II, formally known as the donut hole. Fortunately, the donut hole has closed for both generic and non-generic drugs; you continue to pay the same 25% of the drug cost while your plan pays 75%

If your true-out-of-pocket expense – known as TrOOP – for both Tiers I & II exceed $6,350 (up from $5,100 in 2019) you enter Tier III, or the catastrophic coverage. In this Tier your co-payment continues as it was in 2019 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. "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 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-rata 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.

3. Medicare Coverage Re: Coronavirus

The COVID-19 (also called coronavirus) is one of the most insidious and dangerous disease's ever. As you know it has created a world-wide pandemic that has shuttered many countries, with the number of COVID-19 cases & death tolls steadily rising. According to the Centers for Disease Control and Prevention (CDC), the most vulnerable population to the virus are older adults and people with serious chronic medical problems like heart disease

The good news is that Medicare covers medically necessary items and services related to COVI-19 providing the doctor accepts Medicare. These items include the following:

1. Coronavirus testing – This is considered a clinical lab test and is covered under Medicare Part B. There is no deductible involved.

2. Coronavirus vaccine – There is no vaccine for the virus. Once one is developed and becomes available, it will be covered by Medicare Part D. All Part D plans will be required to cover the vaccine.

3. Skilled Nursing Facility (SNF) – Medicare Part A generally covers SNF if someone comes directly from a hospital after being a patient for 3 days in a row. Under the coronavirus emergency, this qualifier is being waived if someone:

· Needs to be transferred to a SNF due to nursing home evacuations or make room at local hospitals.

· Needs SNF services due to the current Public Health emergency.

4. Telehealth services – This is a full doctor's visit at home via a telephone call or video technology. Medicare has expanded its coverage during the public health emergency to include mental health counseling, preventative health screenings & other medical services. Telehealth services can be offered by doctors, nurse practitioners, clinical psychologist, and licensed social workers.

We are living under very trying conditions during this public emergency crises. Practice social distancing and other CDC guidelines to protect your safety and health.

Informational Update Vol 11 #1 (February 10, 2020)

1. 2019 Medicare Part B Deductible & Premiums –

As you start to visit your Medicare doctors in 2020, you will have to pay deductibles again as they reset January 1. The deductible for Medicare increased $13.00 from $185 to $198. (GHI remains at $50). The portion of the $198 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 $9.10 from $135.50 to $144.60. 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 2019 IRMAA

If you are eligible for 2019 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 2017 or 2018 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.

How do I Know if I am Eligible for 2019 IRMAA?

There are basically 2 ways to determine IRMAA eligibility:

Your 2019 Part B premium was greater than $135.60.

Your 2017 taxable income (2019 Part B premium is based on this amount) was greater than $85,000 if you file individually or $170,000 if you file jointly.

Documents Needed Along 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 2018, indicating how much your Medicare Part B premium was going to be in 2019. (Do not confuse this letter with the one you received this past November, which indicated your 2020 Medicare Part B premium.)

2) The SSA-1099 letter you should have received in January 2020, 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?

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.

When Will I Receive My IRMAA Reimbursement?

If all goes well, you should receive it in October 2020

Reminders:

1) Do not submit original documents. Only copies.

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

2. Question of the Month

Q. Is a Medicare eligible member covered for emergency ambulance service to the hospital?

A. Medicare plus the secondary insurance overs ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health.

Informational Update Vol 10 # 8 December 30, 2019

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

1. 2018 Medicare Part B Differential Reimbursement.

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.

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.

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.

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

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.

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.

Informational Update Vol 10 #5 July 2019

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.

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.

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.

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.

Part B Coverage of Emergency Ambulance Services

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.

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.

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.

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

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.

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.

Informational Update Vol 9 #5 June 2018

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.

<u>How to Receive the Differential Reimbursement</u>

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.

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:

- · 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

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