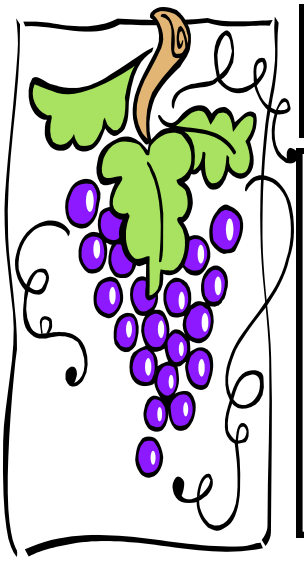

THE GRAPEVINE EXPRESS

SPECIAL EDITION: Medicare Masters

Presented by the Pro Action Yates OFA Health Insurance Information, Counseling, and Assistance Program (HIICAP)

The mission of HIICAP is to prepare, educate, and empower individuals to make health insurance related decisions.

This project was supported by a grant from the U.S. Administration for Community Living and NY Connects.

Changes to Medicare Advantage Marketing Rules

New marketing rules will include the prohibition of:

- *Advertisements that do not mention a specific plan, or use the Medicare name or logo in a misleading way*
- *Marketing of benefits in a service area where those benefits are not available*
- *The use of superlatives (e.g., words like "best" and "most") in marketing unless the material provides documentation to support the statement and the documentation is based on data current or prior year*

It's all part of a regulation the Centers for Medicare & Medicaid Services (CMS) finalized in April 2023 that is designed to crack down on what Health and Human Services Secretary Xavier Becerra has called "misleading marketing schemes by health insurance companies that offer Medicare Advantage plans." Among other provisions, Becerra said, the new rule "would prohibit overly general ads about the Medicare Advantage program that often tend to confuse and mislead those individuals who are eligible to apply for some of these insurance plans."

The final rule takes critical steps to protect people with Medicare from confusing and potentially misleading marketing while also ensuring they have accurate and necessary information to make coverage choices that best meet their needs. The proliferation of certain television advertisements generically promoting enrollment in Medicare Advantage (MA) plans has been a specific topic of concern. Starting Sept. 30, 2023, if Joe Namath, William Shatner or Jimmy Walker wants to sell you on MA plans, they are going to have to disclose what insurance plan they are advertising. And these television pitches can't misuse the Medicare logo or card to lead consumers to believe the celebrity endorsers represent the federal government. As explained by Brendan Rose, an AARP government affairs director, these ads may look very official and lead people to believe that the toll-free number they call goes to the federal government, when in fact, it's a private broker or insurance company.

The new regulation requires brokers, insurance agents and others who market MA plans to fully explain the coverage they sell and to make sure their benefits are actually available in the state or county where a consumer lives. "A lot of these providers will make a commercial and list all these great benefits without saying that because of where you live, you might not be eligible for these benefits," Rose says. MA plans are organized around networks of providers that only cover a certain geographic area.

Another provision in the regulation limits the time an agent or other salesperson can contact a potential enrollee and try to sell them an MA plan. Often, Rose said, "members just get bombarded by cold calls on plans that they might be interested in." The regulation says a broker cannot keep calling someone to sell them a plan 12 months after they first asked for information or expressed interest in a plan.

Sources: AARP "Feds Crack Down on Medicare Advantage Marketing" and 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

Medicaid and Medicare Savings Program Expansion in 2023

In January 2023, the New York Fiscal Year 2023 budget expanded eligibility for Medicaid for older adults and people with disabilities, as well as expanding eligibility for the Medicare Savings Program. Medicaid eligibility expanded from 87% of the Federal Poverty Level to 138%, and the Medicare Savings Program expanded from 135% to 186% of the Federal Poverty Level. The Federal Poverty Level is a standard set by the federal government for administration purposes—like determining income eligibility for certain federal programs. This substantial expansion of eligibility means an estimated 290,000 New Yorkers are now eligible for the Medicare Savings Program and another 200,000 are now eligible for Medicaid.

Medicare Savings Program (MSP):

Monthly income up to $2,280 single/$3,077 Married

- NYS will pay Part B premium for you (No longer deducted from monthly Social Security check)
- Automatically qualify for Full Extra Help (also known as Low Income Subsidy/LIS) which is a benefit directly applied to your Medicare Advantage or Part D plan. This benefit eliminates any Part D annual deductible, and your medication copays will be no more than $4.15 generic or $10.35 brand name for a 30-day supply even during the donut hole. Extra Help will also cover up to $38.90/month of your plan premium.

Qualified Medicare Beneficiary (QMB):

Monthly income up to $1,697 single/$2,288 Married

- QMB is a level within the Medicare Savings Program explained above. If you qualify for QMB, you get all the same benefits with MSP (Part B premium and Extra Help), but QMB will also cover all your copays and coinsurances for medical and hospital services. Those eligible will receive a Medicaid card, though QMB is not full Medicaid. Federal law prohibits Medicare providers from billing you if you are enrolled in QMB. **More info about QMB billing can be found on page 4.
- No asset/resource requirements. Income only.

Medicaid:

Monthly income up to $1,697 single/$2,288 Married

Asset limits: $28,133 single/$37,902 married (does not include your primary residence or one vehicle)

- Health insurance for low-income individuals and families
- Automatically qualify for Medicare Savings Program and *Full* Extra Help benefits listed above, but with lower copays of $1.45 generic and $4.30 brand name
- Besides health insurance, Medicaid also has different programs for those in need of community or institutionally based long-term care, with different eligibility guidelines.

If you meet the income limits above for Medicare Savings Program or Qualified Medicare Beneficiary Program, please contact the Pro Action Office for the Aging for an application and application assistance. Please note, health insurance premiums can be deducted from your monthly income to qualify. Documentation that will be needed for the application is your Medicare card (red, white, blue card), proof of all forms of income, proof of health insurance premiums, and proof of residency (bill or statement with your name, address, and a date within the last 6 months).

This is a New York State Benefits card. This card can be used for SNAP, Temporary Assistance, Medicaid, and the Qualified Medicare Beneficiary program. If you already have one of these cards when you are approved for either Medicaid or QMB, you will begin using this card when you receive health or medical services. If you do not already have one of these cards, they will mail you one. If you do not receive a Benefit card within 10 days after receiving your Notice of Decision from the Department of Social Services, please call 315-536-5183 to request one. In the mean time, you can use the Client ID number listed on your Notice of Decision for billing purposes. Even if you stop receiving benefits at anytime, you should always keep this card safe. If you are eligible for benefits again in the future, you will not be issued a new card unless it is requested.

Qualified Medicare Beneficiary (QMB) Improper Billing

In Medicare, the term improper billing refers to a provider inappropriately billing a beneficiary for Medicare cost-sharing. Cost-sharing can include deductibles, coinsurance, and copayments. Federal law prohibits Medicare providers from billing people enrolled in the Qualified Medicare Beneficiary (QMB) program for any Medicare cost-sharing. This means that if you have QMB, Medicare providers should not bill you for any Medicare-covered services you receive.

More specifically, if you have QMB and are enrolled in Original Medicare, you should not be billed when receiving a Medicare-covered service from either a participating provider (one who takes assignment), or a non-participating provider. If you have QMB and are enrolled in a Medicare Advantage Plan, you should not be billed when receiving a plan-covered service from in-network providers, as long as you meet your plan's coverage rules, such as getting prior authorization to see certain specialists.

To protect yourself from improper billing, be aware that:

- Original Medicare and Medicare Advantage providers who do not accept Medicaid must still comply with improper billing protections and cannot bill you.
- You keep your improper billing protections even when receiving care from Medicare providers in other states. (Note: You can be billed if you are enrolled in a Medicare Advantage Plan and see an out-of-network provider, or if you have Original Medicare and see an opt-out provider)
- You cannot choose to waive these protections and pay Medicare-cost sharing, and a provider cannot ask you to do this.

Remember that if you have QMB, the Medicare providers you see must accept Medicare payment and any QMB payment as the full payment for any Medicare-covered services you received. Providers who violate improper billing protections may be subject to penalties. If you are having issues with a provider who continually attempts to bill you, or if you have unpaid cost-sharing bills that have been sent to collection agencies, call 1-800-MEDICARE or contact your Medicare Advantage Plan.

Source: Medicare Interactive

The Elderly Pharmaceutical Insurance Coverage Program (EPIC)

EPIC is a New York State program that provides secondary drug coverage for those enrolled in Medicare Part D drug plans. This results in additional savings for members to purchase needed medications. EPIC provides secondary prescription coverage for Medicare Part D and EPIC covered drugs after any Medicare Part D deductible is met. EPIC copayments range from $3, $7, $15 and $20 based on the out of pocket cost after the Medicare Part D plan has been billed.

EPIC has two plans: the Fee and Deductible Plans. Lower income members will pay an annual EPIC fee for coverage and will pay EPIC co-payments for drugs. Higher income members must meet an annual EPIC deductible before paying EPIC co-payments for drugs.

For many older adults, it is less expensive to enroll in EPIC and Medicare Part D than just Medicare Part D alone. If eligible, EPIC may pay up to $38.09 towards the Part D drug plan premiums for members with incomes up to $23,000 single or $29,000 married. Higher income members are responsible for paying their Medicare Part D premiums but will receive Part D premium assistance in the form of a reduced EPIC deductible.

It is easy to join EPIC. The person must be a NYS resident, 65 years of age or older, have annual income below $75,000 single or $100,000 married, be enrolled in a Medicare Part D drug plan and not receiving full Medicaid benefits. You may apply for EPIC at any time during the year even if you do not have a Medicare Part D Plan. When eligible older adults become EPIC members, they will receive a Special Enrollment Period from Medicare allowing them to join a Medicare Part D drug plan. If an older adult has union or retiree benefits, they should contact their benefit office to see if they are eligible to join a Part D drug plan.

For further information or an application, please call the toll-free EPIC Helpline at 1-800-332-3742 or the Pro Action Office for the Aging 315-279-4321.

Source: EPIC Outreach Representative

I have both Medicare and Medicaid—What are my coverage options?

Dually eligible New Yorkers have several options for how they receive their Medicare and Medicaid coverage. Those without long-term care needs can either enroll in a Dual-eligible Special Needs Plan (D-SNP) or use fee-for-service Medicaid with their Original Medicare or Medicare Advantage Plan. Those with long-term-care needs can enroll into a Medicaid Managed Long Term Care (MLTC) Plan.

What is a Dual-eligible Special Needs Plan (D-SNP)? D-SNPs are types of Medicare Advantage Plans for individuals enrolled in Medicare and Medicaid (dually eligible individuals). Like other Medicare Advantage Plans, D-SNPs typically require use of an in-network provider for Medicare services. These providers should also accept Medicaid. Cost-sharing varies from plan to plan, and some plans offer zero cost-sharing for enrollees. D-SNP enrollment is voluntary. Some D-SNPs only serve beneficiaries with Medicare and full Medicaid benefits, while others serve those with partial Medicaid benefits, such as individuals enrolled in certain Medicare Savings Programs (MSPs).

What should an individual consider when choosing a D-SNP? A D-SNP could be a good option for individuals interested in consolidating their Medicare and Medicaid coverage. D-SNPs offer networks of providers and facilities that take both Medicare and Medicaid coverage. Most individuals who enroll in a D-SNP should see that Medicaid covers their Medicare cost-sharing, such as deductibles and copayments and plans may also offer extra benefits like Over the Counter and healthy food cards. Keep in mind that enrolling in a standard D-SNP means having separate Medicare and Medicaid benefits. Also, standard D-SNPs do not offer long-term care coverage.

What is an MLTC plan? Managed long-term care (MLTC) is a system that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long-term care plans that are approved by the New York State Department of Health. The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen.

How do you join an MLTC?

1. Apply for Medicaid if you do not already have it. For assistance with applying call 1-800-346-2211 and request application assistance. Assistance will be provided by Finger Lakes Community Health insurance navigators.

2. Schedule an evaluation by calling 855-222-8350. This nurse will come from the Conflict Free Evaluation and Enrollment Center, which is run by New York State. You can be evaluated by the Conflict Free Center before your Medicaid application has been approved. For the evaluation, the nurse will come to your home or call you and ask you a standard list of questions including medical conditions, your symptoms, how you complete your daily activities, and more. You can have a friend or family member present during this visit. The assessment can take up to 3 hours. At the end of the visit, the nurse will tell you right away if you are approved to join MLTC and provide you with information on plans.

3. Choose your MLTC plan from one of the three companies that offer plans in Yates County: Nascentia, iCircle, and Fidelis. The plan you choose may also require another assessment with one of their nurses. (Note: Program of All-Inclusive Care for the Elderly [PACE] and Medicaid Advantage Plans [MAP] are not currently available in Yates County.)

4. Enroll! Once you have chosen the plan that best fits your needs, you may enroll by signing an enrollment form provided by the plan. If you enroll by the 20th of the month, your services will begin on the 1st of the next month. If you enroll after the 20th, your services will not start until the following month. The entire process, from applying for Medicaid to enrolling in a plan, will probably take about 3 months.

How do I get services through my MLTC plan? Once you are enrolled in MLTC, you will be assigned a care manager. Your care manager will call you every month to make sure you are getting the services you need. They will visit you in your home every six to twelve months. If you want a new service, or want more of an existing service, you should call your care manager. This is called a service authorization. When you ask for a service authorization, your MLTC plan must send you a written notice of their decision within 14 days.

Who can beneficiaries contact if they have additional questions about MLTC?

- New York Medicaid Choice (888-401-6582) to find out which plans are available in a specific county and/or to enroll in coverage.
- Individuals experiencing problems with their coverage or need help navigating their options can contact the Independent Consumer Advocacy Network (ICAN) at 844-614-8800.

Sources: Medicare Interactive, NYS Dept. of Health, and the Independent Consumer Advocacy Network (ICAN)

Does Medicare cover a second opinion?

A second opinion is when you ask a doctor other than your regular doctor for their view on symptoms, an injury, or an illness you are experiencing in order to better help you make an informed decision about treatment options.

There are countless reasons why someone would want a second opinion, but here are just a few examples:

- You have a rare condition with which another doctor may have more experience or training.
- Your doctor recommends a treatment that is risky, invasive, involves surgery, or has lifelong consequences.
- You want assurance that you've considered all treatment options.
- You believe your diagnosis could be incorrect.

Original Medicare covers second opinions if a doctor recommends that you have surgery or a major diagnostic or therapeutic procedure. Medicare will also cover a third opinion if the first and second opinions are different from each other. The second and third opinions will be covered even if Medicare will not ultimately cover your procedure. Do note, however, that Medicare does not cover second and third opinions for excluded services, such as cosmetic surgery.

If you have a Medicare Advantage Plan, your plan may have different cost and coverage rules for second and third opinions. Contact your plan for more information about costs and restrictions.

Some people may feel uncomfortable or nervous asking their doctor for a second opinion. Doctors are professionals and most will respect your want for a second opinion. Many consider it standard medical practice to get another opinion. In fact, your doctor may even be ready to give you referrals for a second opinion. Trust yourself and remember that you are your strongest advocate!

Source: Medicare Interactive "Dear Marci", April 2023

How do VA benefits work with Medicare?

VA benefits are administered by the federal government for veterans—people who served on active duty in the U.S. Armed Forces for a required period of time and received an honorable discharge or release. VA benefits include pensions, educational stipends, and health care, among other benefits. It is important to know that VA benefits do not work with Medicare, though you can be enrolled in both.

- In order for your VA coverage to pay for your care, you must generally receive health care services at a VA facility.
- In order for Medicare to pay for your care, you must receive care at a Medicare-certified facility that works with your Medicare coverage.
- VA benefits will not pay for Medicare cost-sharing like deductibles, copayments, or coinsurances.

This means that if you choose not to enroll in Medicare and to keep only your VA coverage, you will not have health insurance for facilities outside the VA system. Enrolling in Medicare gives you more flexibility in what doctors and facilities you go to, while also having VA benefits to cover things not covered by Medicare, such as hearing aids and dental care.

Some people choose to enroll in Medicare Part A for added hospital insurance because it's often premium-free, but they turn down Part B because of the monthly premiums. In this scenario, though, you would likely face a premium penalty and coverage gap if you decided to enroll in Part B in the future.

VA benefits do offer creditable drug coverage. This means that if you are enrolled in VA drug coverage, you can delay Medicare Part D enrollment without having a late enrollment penalty. Be sure to compare the costs and benefits of Part D and your VA drug coverage to decide which best suits your needs. Typically, VA drug coverage has no premiums and no or limited copayments for prescriptions—but you must use VA pharmacies and facilities. You may want Part D coverage if you:

- Live far from a VA pharmacy or facility, or do not want to use a VA provider to get prescriptions.
- Want the flexibility of filling prescriptions at retail pharmacies or find the VA formulary too restrictive.
- Reside in a non-VA nursing home and want to get prescriptions from the long-term care pharmacy that works with your nursing home.
- Qualify for full Extra Help, which has lower copays than VA coverage.

If you decide to enroll in Medicare Part B and Part D, you should do so during your Initial Enrollment Period (IEP). Your IEP is the three months before your 65th birthday month, the month of your 65th birthday, and the three months after.

Source: Medicare Interactive "Dear Marci", November 2022

Medicare and Home Health Care

Home health care includes a wide range of health and social services delivered in your home to treat illness or injury. Services covered by Medicare's home health benefit include intermittent skilled nursing care, therapy, and care provided by a home health aide.

Medicare covers your home health care if:

- You are homebound, meaning it is extremely difficult for you to leave your home and you need help doing so.
- You need skilled nursing services and/or skilled therapy care on an intermittent basis.
- You have a face-to-face meeting with a doctor within the 90 days before you start home health care, or the 30 days after the first day you receive care. This can be an office visit, hospital visit, or in certain circumstances a face-to-face visit facilitated by technology (such as video conferencing).
- Your doctor signs a home health certification confirming that you are homebound and need intermittent skilled care. It must also state that your doctor has approved a plan of care for you and that the face-to-face meeting requirement was met. Your doctor should review and certify your home health plan every 60 days.
- And, you receive care from a Medicare-certified home health agency (HHA).

Medicare covered home health services:

- *Skilled nursing services:* Services performed by or under the supervision of a licensed or certified nurse to treat your injury or illness.
- *Skilled therapy services:* Physical, speech, and occupational therapy services that are reasonable and necessary for treating your illness or injury, and performed by or under the supervision of a licensed therapist.
- *Home health aide:* Medicare pays in full for an aide if you require skilled care (skilled nursing or therapy services). A home health aide provides personal care services, including help with bathing, toileting, and dressing. Medicare will not pay for an aide if you only require personal care and do not need skilled care.
- *Medical social services:* Medicare pays in full for services ordered by your doctor to help you with social and emotional concerns you have related to your illness. This may include counseling or help finding resources in your community.
- *Medical supplies:* Medicare pays in full for certain medical supplies, such as wound dressings and catheters, when provided by a Medicare-certified home health agency (HHA).
- *Durable medical equipment (DME):* Medicare pays 80% of its approved amount for certain pieces of medical equipment, such as a wheelchair or walker. You pay 20% coinsurance (plus up to 15% more if your home health agency does not take assignment).

Medicare Advantage and home health: All Medicare Advantage Plans must provide at least the same level of home health care coverage as Original Medicare, but they may impose different rules, restrictions, and costs. Depending on your plan, you may need to get care from a home health agency (HHA) that contracts with your plan, request prior authorization or a referral before receiving home health care, pay a copayment for your care (Original Medicare fully covers home health). Know that HHAs can choose who to accept as a patient or refuse to provide you with home health services if they do not believe they can ensure your safety. If no HHA in your plan's network will take you as a patient, call your plan. Your plan must provide you with home health care if your doctor says it is medically necessary. If no in-network HHA will provide you with care, but an out-of-network HHA will, your plan must provide coverage for your out-of-network home health care. If no HHA in your area can provide you with care, speak to your doctor about other options for receiving care. If you need information about the costs and coverage rules for home health care, or if you are experiencing problems, contact your Medicare Advantage Plan.

Plan of care: Before you receive Medicare-covered home health care, your home health agency (HHA) should assess your condition to create a plan of care. Generally, your plan of care will list the types of health services and items you need, how often you will receive services, and the predicted outcomes of treatment. Your doctor must sign the plan of care at the start of your care or soon after it starts. The plan of care is often paired with the home health certification form that your doctor must sign to show you need care. The first time your doctor certifies your eligibility for home health care, you must have a face-to-face meeting to discuss the reason you need care. This meeting must take place within the 90 days before you start care or the 30 days after the first day you receive care. Your initial plan of care and certification will last 60 days. If you need additional care, the certification and plan of care can be renewed for as many 60-day periods as necessary, as long as your doctor continues to sign them. Make sure that your doctor agrees with the plan of care and thinks it contains all the care you need. A face-to-face meeting is not required for recertification.

Source: Medicare Rights Center, Medicare Interactive

Did you know you can register your phone number on "do not call" lists and opt out of marketing mailings?

This could be a great way to help prevent potential scams and fraud!

- Marketing Mailings: Visit optoutprescreen.com or call 1-888-567-8688 (Deaf and hard of hearing consumers can call 7-1-1 and refer the Relay Operator to 1-800-821-9631). Opt-Out is the official Consumer Credit Reporting Industry website to accept and process requests from consumers to Opt-In or Opt-Out of firm offers of credit or insurance.
- Phone Calls: Visit DoNotCall.gov or call 1-888-382-1222 (TTY: 1-866-290-4236) The National Do Not Call Registry was created to stop unwanted sales calls, from real companies. It's free to register your home or cell phone number. If you've already added your phone number to the Do Not Call Registry and are still getting a lot of unwanted calls, odds are the calls are from scammers. The FTC does not and cannot block calls. The Registry can't stop calls from scammers who ignore the Registry. Other calls still allowed under FTC rules for those listed on the Registry include political calls, charitable calls, debt collection calls, purely informational calls, and surveys—but these calls cannot also include a sales pitch.

Source: Senior Medicare Patrol, Opt-out, and the Federal Trade Commission

Transition Forward from the COVID-19 Public Health Emergency

The COVID-10 public health emergency (PHE) ended May 11, 2023. This means that some of the waivers and flexibilities that changed Medicare coverage during the emergency are no longer in place and some Medicare coverage and cost rules are returning to what they were before 2020.

- *Vaccines:* People with Medicare coverage will continue to have access to COVID-19 vaccinations and boosters without cost sharing after the end of the PHE. Beneficiaries should bring their red, white, and blue Medicare card to their vaccination appointment, even if they have a Medicare Advantage Plan. If they do not bring their card, their provider may ask for their Social Security number in order to look up their Medicare number and bill Medicare.
- *PCR and Antigen Testing:* Original Medicare continues to cover COVID-19 PCR tests (which identify genetic material) and antigen tests (which are often referred to as rapid tests) with no cost-sharing (no deductible, coinsurance, or copayment) when the test is ordered by a physician or other health care practitioner. Medicare Advantage Plans must continue to cover COVID-19 PCR and antigen tests, but cost-sharing may apply. A beneficiary should contact their plan to learn more about costs. Medicare Advantage Plans may also continue to cover OTC at-home tests. A beneficiary should contact their plan to learn if this supplemental benefit is offered, and what rules, restrictions, or costs may apply.
- *Over the Counter Testing:* By law, Medicare does not generally cover over-the-counter services and tests. Original Medicare does not cover over-the-counter (OTC) at-home tests as of May 11, 2023. However, some Medicare Advantage plans may continue to provide coverage as a supplemental benefit.
- *Treatments:* There is no change in Medicare coverage of treatments for those exposed to COVID-19 once the PHE ends, and in cases where cost sharing and deductibles apply now, they will continue to apply. Generally, the end of the COVID-19 PHE does not change access to oral antivirals, such as Paxlovid and Lagevrio. Medications that are given while people are inpatients will be covered under Part A or a beneficiary's Medicare Advantage Plan. Some medications, like Remdesivir, are administered by providers as injections or infusions and will be covered under Part B or a person's Medicare Advantage Plan. Cost-sharing may apply. Medicare will also still cover antibody testing when applicable.
- *Telehealth:* During the PHE, individuals with Medicare had broad access to telehealth services, including in their homes, without the geographic or location limits that usually apply. These waivers were included as provisions of The Consolidated Appropriations Act, 2023, which extended many telehealth flexibilities through December 31, 2024, such as:
    - People with Medicare can access telehealth services in any geographic area in the United States, rather than only in rural areas.
    - People with Medicare can stay in their homes for telehealth visits that Medicare pays for rather than traveling to a health care facility.
    - Certain telehealth visits can be delivered using audio-only technology (such as a telephone) if someone is unable to use both audio and video (such as a smartphone or computer).

  However, if an individual receives routine home care via telehealth under the hospice benefit, this flexibility will end at the end of the PHE. MA plans may offer additional telehealth benefits. Individuals in an MA plan should check with their plan about coverage for telehealth services.

Sources: SHIP TA Center Fact Sheet and CMS Press Release "CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency"

Yates County Office for the Aging
417 Liberty Street, Suite 1116
Penn Yan, NY 14527
Phone: 315-279-4321
Fax: 315-536-5514
Email: ycofa@proactioninc.org
www.proactioninc.org

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Medicare Plan Annual Notice of Change

The Annual Notice of Change (ANOC) is a notice you receive from your Medicare Advantage or Part D plan in late September. The ANOC gives a summary of any changes in the plan's costs and coverage that will take effect January 1 of the next year. It will highlight changes to the plan's drug list and pharmacy network, provider network, and coverage costs and changes. Review this notice to see if your plan will continue to meet your health care needs in the following year. If you do not receive an ANOC, you should contact your plan. The ANOC is typically mailed or emailed with the plan's Evidence of Coverage (EOC), which is a more comprehensive list of the plan's costs and benefits for the upcoming year.

Things you should consider when reviewing your ANOC Letter:

- *Does the plan for next year still cover your important medications?*
- *Are there any coverage restrictions for those medications, such as quantity limits or prior authorizations?*
- *How much will you pay for generic and brand name drugs?*
- *Has the monthly premium changed?*
- *Has the Part D drug deductible increased?*
- *Are your doctors and hospitals still in the plan's network next year?*
- *Will you need a referral from your PCP to see a specialist?*
- *How much is the plan's out-of-pocket maximum for next year? Has it increased from this year?*
- *In the event of a serious illness, do you have the funds available to cover that out-of-pocket maximum?*
- *How much are the copays for healthcare services that you know you will need?*
- *Is there a medical deductible? Is there a drug deductible?*

Source: Medicare Interactive