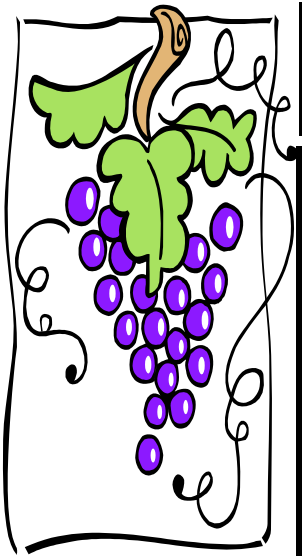

THE GRAPEVINE EXPRESS

SPECIAL EDITION: Medicare Masters

August 2026

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

This document was supported, in part, by grant numbers 90SAPG0159 from the Administration for Community Living (ACL), Department of Health and Human Services, Washington, D.C. 20201.

Time for Medicare Open Enrollment

The Annual Medicare Open Enrollment Period begins October 15th and ends December 7th, and during this time Medicare beneficiaries can make certain changes to their coverage, including switching prescription drug plans or between traditional (sometimes called Original) Medicare and Medicare Advantage (MA).

Understandably, Medicare beneficiaries in Yates County have experienced numerous disruptions to the Medicare plan market in our region over the last couple years. High numbers of plan terminations and limited resources for assistance have caused much frustration. Here are some tips to help you begin to navigate the approaching Medicare Open Enrollment Period:

1. Read your mail! Reading the mail you receive from your insurance company is important to do year-round, but it is especially important to open and read your mail in preparation for the Medicare Open Enrollment period, starting in September.

2. Review your current Medicare health and drug coverage. If you have MA or a Part D prescription drug plan (PDP), you should receive an Annual Notice of Change (ANOC) from your plan, typically by the end of September. Review this document for any changes in the plan's costs, benefits, and/or rules for 2027. If you do not receive an ANOC from your plan, you may have received a plan termination notice instead explaining that your plan will no longer be offered in 2027. If you receive a plan termination notice, you must enroll in a new plan by 12/31/2026 to avoid starting 2027 without coverage.

3. Know your resources. Pro Action Yates Office for the Aging has numerous options for you to utilize when researching and comparing options. Learn more about those options on the next page! Please note, Medicare Open Enrollment appointments will not be scheduled until after October 1st, 2026.

4. Consider your options. Whether you are happy with your current coverage or not, it is recommended that you review all of your options each year. Does a Medicare Advantage plan fit your needs best, or has your situation changed warranting a switch to Original Medicare with a Medigap Supplemental plan with a Stand-alone Part D plan?

5. Make changes during Fall Open Enrollment. If you find a plan that better meets your needs, the best way to enroll during Fall Open Enrollment is to call 1-800-MEDICARE or enroll online using the Medicare Plan Finder at www.medicare.gov/plan-compare. Your new coverage will take effect on January 1. Make sure you document the conversation, including the date, the representative you spoke to, and any outcomes or next steps. You may need this information later if there are problems with your enrollment.

Open Enrollment Resources for Yates County Residents

The Medicare Open Enrollment period is upon us. While it is understandable that a one on one appointment is the preferred option for beneficiaries to receive Medicare counseling, appointments are high in demand and low in quantity. Pro Action Yates Office for the Aging strives to serve as many individuals as possible on an annual basis, and has created multiple resources in different formats to provide education and decision making support to Yates County Medicare beneficiaries.

- Reference Guides: Yates County Medicare Reference Guides are a comprehensive packet of information and plan offerings, tailored specifically to Medicare beneficiaries residing in Yates County. Packets include Federal Medicare updates and all plans that are available in Yates County. All information included can be used to educate and empower Medicare beneficiaries to make Medicare related decisions. Packets will be available for pick up or by mail on October 15th, 2026.
- Alternative Medicare Counseling Options Handout: This handout provides a through listing of all other resources that Yates County residents could access to assist them with education, comparing options, and completing enrollments.
- Presentations: Educational opportunity that includes a guided review of Medicare Reference Guides and plan options. Presentations are held on different days and times, and at different locations, to accommodate as many individuals across the county as possible. Presentation attendance is highly encouraged.
- 2nd Annual Medicare and Wellness Fair: Meet with insurance representatives from multiple companies to learn about their plans and receive enrollment assistance, as well as learn about different services and wellness resources available in Yates County. Date to be announced.

Yates County Medicare Beneficiaries are highly encouraged to take advantage of all resources available this fall.

Who is Eligible for SSI?

Supplemental Security Income, or SSI, is a federal benefit program administered by the Social Security Administration that provides safety-net financial support for people in need. You may qualify for monthly SSI payments if: you are 65 or older, blind or have a disability; you are a U.S. citizen or lawful resident; and you have very limited income and financial resources.

In 2026, the SSI standard for limited income is income of up to $994 a month for an individual or $1,491 a month for a couple in which both spouses are beneficiaries. What constitutes income is somewhat elastic; Social Security has a long list of what types of earnings, payments and non-cash assistance it considers “countable income” for the purpose of determining SSI eligibility and calculating payments. (If you also receive Social Security benefits, they count.)

Similarly, not all assets are “countable resources” for considering SSI claims. Broadly, countable resources include cash and financial assets that can be turned into cash, such as stocks, bonds or property. They do not include the home you live in, a vehicle you rely on for transportation, or household goods, among other things. To qualify, your countable resources should not exceed $2,000 for an individual and $3,000 for a couple.

These are just the broad outlines of eligibility for SSI — claims are evaluated by Social Security on a case-by-case basis, subject to a complex set of rules and calculations. You’ll find more information at www.ssa.gov/ssi, where Social Security’s Benefit Eligibility Screening Tool can also help you determine if you might qualify. You may also call Social Security at 1-800-772-1213 (national) or 1-866-331-7759 (Geneva Office).

Source: “Who is eligible for SSI?” by Andy Markowitz and Tracy Thompson, AARP

Medicare Prescription Payment Plan (MPPP)

Since 2025, you have the option to sign up for a payment plan for Part D out-of-pocket costs. The MPPP allows you to spread your drug costs throughout the year, with the goal of helping you manage your monthly expenses. This means a January bill for $2,100, the Part D out-of-pocket limit for 2026, could be paid off by year's end for an average of $175 a month through the program. Even if you start in April, you would be able to pay a little more than $233 a month until the end of the year. And you won't be charged interest like with a credit card or an installment loan. Note that the MPPP does not change or lower your drug costs. It may, however, help your medication costs feel more manageable, by spreading the costs throughout the year. There is no cost to participate in the program. Although you can opt in to the program at any time, you will likely not see a significant benefit if you opt in during the last few months of the year.

When you sign up for the MPPP, your plan will communicate your choice to your pharmacy. You should pay $0 at the pharmacy for your covered Part D drugs. Your plan will pay the cost-sharing at the time of your purchase and send monthly bills to you for the cost-sharing amounts. You pay no fees or interest, even if your payment is late. Those who fall at least two months behind in their payments can be disenrolled from the Medicare Prescription Payment Plan. If removed, you will still be enrolled in your Medicare Part D plan and you still need to pay what you owe. Once you pay what is owed, you can rejoin the Medicare Prescription Payment Plan at any time by contacting your plan.

To sign up for the payment plan, contact your Medicare Advantage or Stand Alone Part D plan directly.

Source: SHIPTA Counseling Tips, March 2025 and AARP "Hurry to Sign Up for the 2026 Medicare Prescription Payment Plan", March 2026

Medicare Coverage of Emergency and Ambulance Services

If you have Original Medicare, Part B covers emergency room services anywhere in the U.S. Medicare Advantage Plans must also cover emergency services anywhere in the country. For emergency care, remember that:

- Your plan can't require you to see an in-network provider.
- You don't need a referral.
- There are limits on how much your plan can bill you if you receive emergency care out of your plan's network. Specifically, you will be billed either $50 or your plan's in-network cost for emergency services, whichever is less.
- Your plan must cover medically necessary follow-up care related to the medical emergency if delaying care would endanger your health.
- You have the right to appeal if your plan denies a claim for emergency care.

If you have Original Medicare, Part B covers emergency ambulance services if:

- An ambulance is medically necessary, meaning it's the only safe way to transport you.
- The reason for your trip is to get a Medicare-covered service or return from getting care.
- You are transported to and from certain locations, and, the transportation provider meets Medicare ambulance requirements.

To be eligible for coverage of non-emergency ambulance services, you must be bedbound or need essential medical services during your trip that are only available in an ambulance. This could include administration of medications or monitoring of vital functions. Original Medicare never covers ambulette services (specialized, non-emergency medical transportation (NEMT) options for individuals with limited mobility who do not require urgent medical care).

If you have a Medicare Advantage Plan, your plan must cover the same ambulance services that Original Medicare covers but can do so with different costs or network restrictions. Contact your plan directly to learn more about how it covers ambulance transportation. If your condition was not an emergency but appeared to be an emergency, Original Medicare or your Medicare Advantage Plan must still cover your care.

Source: Medicare Rights Center "Dear Marci" March, 2026

Medicare Marketing Rules for Plans

Insurance companies selling Medicare private plans must follow certain rules when promoting their products. These rules are meant to prevent plans from presenting misleading information about a plan's costs or benefits, also known as marketing fraud. Medicare private plans are allowed to conduct certain activities. For instance, companies can market their plan through direct mail, radio, television, and/or print advertisements. Agents can also visit your home if you invite them for a marketing appointment.

Insurance agents cannot:

- Call you if you did not give them permission to do so.
- Visit you in your home, nursing home, or other place of residence without your invitation.
- Ask for your financial or personal information (like your Social Security number, Medicare number, or bank information) if they call you.
- Provide gifts or prizes worth more than $15 to encourage you to enroll (gifts or prizes that are worth more than $15 must be made available to the general public, not just to people with Medicare).
- Disregard federal and state consumer protection laws for telemarketing, the National Do-Not-Call Registry, or do-not-call-again requests (you can register online for the National Do-Not-Call Registry at donotcall.gov or by calling 1-888-382-1222 from the number you wish to register).
- Market their plans at educational events or in health care settings (except in common areas).
- Sell you life insurance or other non-health products at the same appointment (known as cross-selling), unless you request information about such products.
- Compare their plan to another plan by name in advertising materials.
- Use the term "Medicare-endorsed" or suggest that their plan is a preferred Medicare plan. Plans can use Medicare in their names as long as it follows the plan name (for example, the Acme Medicare Plan) and the usage does not suggest that Medicare endorses that particular plan above other Medicare plans.
- Imply that they are calling on behalf of Medicare.

You are being misled if an agent from an insurance company says that you:

- Must sign up for a Medicare Advantage Plan to get Medicare drug coverage (you can also keep Original Medicare and enroll in a stand-alone Part D plan).
- Will pay a higher Part B premium unless you sign up for a certain plan (some plans help pay your Part B premiums or charge additional premiums, but your Part B premium will not increase based on your coverage choices).
- Must invite a plan representative to your home to get information about the plan or to enroll.
- Can switch back to Original Medicare at any time if you are dissatisfied with the plan, without providing information about enrollment periods.
- Will receive additional benefits that are actually Medicare-covered services.
- Will receive additional benefits, such as dental or vision, that are actually covered by other insurance you have or are eligible for (such as Medicaid).
- Will lose your Medicaid benefits unless you sign up for a certain plan.

Never feel pressured to join any plan. Always make sure you understand what the plan is offering you, and how all your benefits are affected. Ask to receive information about the plan's benefits in writing. If you suspect that an agent is not following the rules, save documented proof (such as the agent's business card or marketing materials).

To report fraud: Contact 1-800-MEDICARE (633-4227), the Senior Medicare Patrol (SMP) Resource Center (877-808-2468), or the Inspector General's fraud hotline at 1-800-HHS-TIPS (447-8477). Medicare will not use your name while investigating if you do not want it to.

Source: Medicare Rights Center

SNAP Program Underutilized Amongst Older Adults in Yates County

The National Council on Aging recently released a national report using their new Benefits Participation Map tool that showed only 36.3% of eligible older adults in Yates County are receiving SNAP benefits. If you are interested in applying for SNAP benefits, you can do so online at mybenefits.ny.gov or you may request a paper application from Pro Action Yates Office for the Aging (OFA) or Yates County Department of Social Services by calling 315-536-5183. OFA is also available to assist with paper applications by calling 315-279-4321.

Household Size	Maximum Benefit Allotment	Monthly Gross Income Guidelines for Households without Earned Income (no elderly or disabled member)	Monthly Gross Income Guidelines for Households with Earned Income (no elderly or disabled member)	Monthly Gross Income Guidelines for Households with an Elderly OR Disabled Member and Households with Dependent Care Expenses
1	$298	$1,696	$1,957	$2,608
2	$546	$2,292	$2,644	$3,525
3	$785	$2,888	$3,332	$4,442

Eligibility information for larger households can be found at: https://otda.ny.gov/programs/snap/

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 $58.82 per month 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. 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 Yates Office for the Aging 315-279-4321.
Office for the Aging can also assist with applications.

Source: EPIC Outreach Representative

Original Medicare and Medicare Advantage Appeals

If you were denied coverage for a health service or item, you may appeal the decision. There is more than one level of appeal, and you have the right to continue appealing if you are not successful at the first level. Be aware that at each level there is a separate timeframe for when you must file the appeal and when you will receive a decision.

How do I begin an appeal if I have Original Medicare? Start your appeal by following the appeal instructions listed on your Medicare Summary Notice (MSN) or Redetermination Request form. This includes circling the denied service listed and filling out the shaded section at the end of the MSN. Then, send your appeal to the Medicare Administrative Contractor (MAC) within 120 days of the date on your MSN. The MAC's name and address are listed in the shaded section of your MSN. This will start your appeal. If your provider sends you a bill for this service, let your provider's billing office know that you are in the process of appealing Medicare's coverage decision. *The MAC should make a decision within 60 days.* If your appeal is successful, your service or item will be covered. If your appeal is denied, you can move on to the next level following the instructions on the MAC denial notice.

How do I begin an appeal if I have a Medicare Advantage Plan? *If you were denied coverage for a health service or item before you received the service or item,* you will first need to get an official written decision from your plan, called a Notice of Denial of Medical Coverage. Follow the instructions on the Notice of Denial of Medical Coverage and file your appeal within 60 days of the date on the notice. You will need to send a letter to your plan explaining why you need the service or item. *Your plan should make a decision within 30 days.* If the appeal is successful, your service or item will be covered. If your appeal is denied, you should receive a written denial notice. Your plan should also automatically forward your appeal to the next level, the Independent Review Entity (IRE).

If you were denied coverage for a health service or item that you have already received, start your appeal by following the instructions on the notice you received from your plan. Make sure to file your appeal within 60 days of the date on the notice. You will most likely need to send a letter to the plan explaining why you needed the service you received. *Your plan should make a decision within 60 days.* If your appeal is successful, your service or item will be covered. If your appeal is denied, you should receive a written denial notice. Your plan should automatically forward your appeal to the next level, the Independent Review Entity (IRE).

How can I strengthen my appeal? ***Read all notices*** that you received from Medicare or your plan before starting an appeal. If you have Original Medicare, carefully read your Medicare Summary Notice (MSN) to see what services were or were not covered. If you have a Medicare Advantage Plan, carefully read your Explanation of Benefits (EOB) to see what services were or were not covered. ***Contact your health care provider*** before appealing to ensure a billing error was not made. ***Call 1-800-MEDICARE or your plan*** to see why the service is not being covered. Your appeal letter should address the reason for denial by Medicare or your plan. ***Keep copies of all documents*** sent and received during the appeal. Do not send original versions of important documents and if possible, send your appeal with certified mail or delivery confirmation. ***Include a letter of support from your health care provider.*** This letter should explain the medical necessity of your care and support your appeal.

How do I request a good cause extension for a late appeal? A late appeal may still be considered after the deadline to appeal has passed, if you can show good cause for not filing on time. Extension requests are considered on a case-by-case basis, so there is no complete list of acceptable reasons for filling a late appeal. Some examples, however, include that you or a close family member fell ill and prevented you from handling business matters, or the notice you are appealing was mailed to the wrong address. If you think you have a good reason for not appealing on time, send in your appeal as you normally would and include a clear explanation of why your appeal is late. If the reason has to do with illness or other medical conditions, a letter or supporting documentation from your health care provider can be helpful.

When should I file a grievance instead of an appeal? If you are dissatisfied with your Medicare Advantage or Part D prescription drug plan for any reason, you can choose to file a grievance. A grievance is a formal complaint that you file with your plan. It is not an appeal. Times when you may wish to file a grievance include if your plan has poor customer service or you face administrative problems (such as the plan taking too long to file your appeal or failing to deliver a promised refund). In some cases, you may want to file both an appeal and a grievance. To file a grievance, send a letter to your plan's Grievance and Appeals department within 60 days of the event that led to the grievance. Check your plan's website or contact them by phone for the address. Your plan must investigate your grievance and get back to you within 30 days. If you have not heard back from your plan within this time, you can check the status of your grievance by calling your plan or 1-800-MEDICARE.

Source: Medicare Rights Center, Senior Medicare Patrol, and SHIP TA Center

Medicare GLP-1 Bridge Program

The Medicare GLP-1 Bridge is a short-term demonstration run by CMS that will provide eligible Medicare Part D beneficiaries with access to certain GLP-1 drugs between July 1, 2026, and December 31, 2027. The Medicare GLP-1 Bridge will operate outside of the Medicare Part D benefit's coverage. CMS will use a single central processor to manage prior authorization, claims adjudication, and payment to pharmacies for the Medicare GLP-1 Bridge, separate from an individual's Part D benefit.

To access GLP-1 medications via the Medicare GLP-1 Bridge, an eligible beneficiary must have a medical provider submit a prior authorization request and a prescription for an eligible GLP-1 drug for a use covered under the demonstration.

Covered medications (subject to change): Foundayo®, Wegovy® (injection and tablets), and Zepbound® (KwikPen®).

Eligibility: To get the GLP-1 drugs listed above under this program, you must meet all four of these requirements:

- *You have Medicare Part D drug coverage*, under either a standalone Medicare Drug Plan or a Medicare health plan that includes drug coverage. You're not eligible if your only Medicare coverage is through certain special plan types (like private fee-for-service plans, cost contract plans or a PACE organization). If you're not sure what type of plan you have, call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- *You're not eligible to receive a GLP-1 drug through your Medicare drug plan*. If you've been using a GLP-1 drug paid for by your Medicare drug plan for any reason, you need to keep getting your GLP-1 drug through your plan. GLP-1 drugs are defined as products with the following active ingredients: Semaglutide, Tirzepatide, Orforglipron, Dulaglutide, and Liraglutide.
- *You don't have type 2 diabetes, moderate-to-severe sleep apnea, or fatty liver disease*. If you have any of these conditions, contact your Medicare drug plan — they may already cover a GLP-1 drug for you.
- *You're at least 18 years of age AND at least one of these is true*:
    - You have a Body Mass Index (BMI) of 35 or higher
    - Your BMI is 30 or higher, and you have certain types of heart failure OR high blood pressure that's hard to control OR chronic kidney disease (stage 3a or above)
    - Your BMI is 27 or higher, and you have prediabetes OR you've had a heart attack, stroke or blocked arteries in your legs or arms

Costs: Under the Medicare GLP-1 Bridge, participating manufacturers will provide eligible GLP-1 drugs at a net price of $245 per monthly supply and eligible beneficiaries will pay a copay of $50. No part of the $245 net price for eligible GLP-1 drugs prescribed for uses covered under the Medicare GLP-1 Bridge would count toward an eligible beneficiary's gross covered prescription drug costs (GCPDC), and no part of the $50 copay would count toward the beneficiary's true out-of-pocket costs (TrOOP) under their Part D plan. In addition, the $50 copay for eligible beneficiaries would remain the same, regardless of the phase of the Part D benefit an eligible beneficiary is in when they fill a prescription for an eligible GLP-1 drugs covered under the Medicare GLP-1 Bridge. Similarly, low-income cost-sharing subsidies would also not apply to any portion of the copay.

Source: Centers for Medicare and Medicaid Services

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

NON-PROFIT ORG.

U.S. POSTAGE
PAID
PERMIT NO. 136
PENN YAN, NY 14527

ProAction of Steuben and Yates, Inc.

The Grapevine Express
Special Edition:
Medicare Masters
August 2026

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?*
- *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?*
- *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