

**A COMPLETE GUIDE TO
HEALTH CARE COVERAGE FOR
OLDER NEW YORKERS
2016**

紐約市老年人
醫療保險
完全指導手冊
2016



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This guide has been developed by the New York City Department for the Aging's Health Insurance Information, Counseling and Assistance Program (HIICAP) to help older New Yorkers better understand the health care coverage options currently available in New York City. The topics include Medicare Parts A and B, "Medigap" insurance, Medicare Advantage health plans, Medicare Part D, Medicare Savings Programs, Medicaid, and Long-Term Care Insurance. The information detailed here is current for the year 2016. Use it in good health!

HIICAP is New York's source for free, current and impartial information about health care coverage for older people. The HIICAP Helpline can assist you in getting your questions answered. Please call 311 and ask for HIICAP to speak with one of our trained counselors.

We have HIICAP counselors available to speak with you over the phone or meet with you in person at one of our counseling sites. Simply call our helpline for a referral to the counselor nearest you.

Please note that inclusion of specific health care benefit programs does not necessarily constitute endorsement of these programs on the part of the New York City Department for the Aging.

Dial 311 for information regarding this and other City services.

www.nyc.gov/aging
www.aging.ny.gov/healthbenefits

CALL 311 AND ASK FOR HIICAP



本指導手冊是由紐約市老人局的醫療保險資訊諮詢與協助計畫 (HIICAP) 製作，以協助紐約市老年人更加瞭解紐約市目前所提供的醫療保險選項。主題包括聯邦醫療保險 (Medicare) A 部分與 B 部分、聯邦醫療保險補充保險 (Medigap)、聯邦醫療保險優勢保健計畫、聯邦醫療保險 (Medicare) D 部分、聯邦醫療保險免保費計畫、醫療補助 (Medicaid) 及長期護理保險。此處所提供的是 2016 年最新資訊。請善加利用以維持良好健康！

HIICAP 為紐約市老年人提供免費、最新且公正的醫療保險資訊來源。HIICAP 專線能協助您解答疑問。請致電 311 洽詢 HIICAP 與受過專業訓練的輔導人員洽談。

HIICAP 輔導員可透過電話與您洽談或在輔導處與您見面。只要致電我們的專線，請其轉介最接近您所在地點的輔導員即可。

請注意，紐約市老人局所提供的信息並不構成這些計畫的擔保或推薦。

請致電 311 以取得與此有關的資訊及紐約市所提供的其他服務。

www.nyc.gov/aging
www.aging.ny.gov/healthbenefits

請致電 311 洽詢 HIICAP

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MEDICARE

Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people and people with kidney failure. It has four components:

- Hospital Insurance (Part A).
- Medical Insurance (Part B).
- Medicare Advantage plans (Part C - HMOs, PPOs, Special Needs Plans, Medical Savings Accounts, and Private Fee for Service Plans). Medicare Advantage plans provide hospital and medical coverage. If someone joins a Medicare Advantage plan, they will have coverage through that private plan, not through "original Medicare."
- Prescription Drug Coverage (Part D). Medicare Advantage enrollees who want drug coverage must get that coverage through their plan. Enrollees in "original Medicare" who want drug coverage sign up for a stand-alone Part D plan.

Who is Eligible for Medicare?

You are eligible for Medicare if you are 65 years old or older, and a citizen or permanent resident of the United States for at least five consecutive years. People under age 65 may qualify for coverage after receiving Social Security Disability Insurance (SSDI) for 24 months; people with Amyotrophic Lateral Sclerosis (ALS) qualify the first month they receive SSDI. People with end stage renal disease (ESRD) can qualify for Medicare, regardless of age. A worker, as well as a worker's spouse (including same-sex spouse) or children may be eligible for Medicare, based on the worker's work record, if she or he receives continuing dialysis for permanent kidney failure or had a kidney transplant, even if no one else in the family is getting Medicare. If you or your spouse (including same-sex spouse) are insured through Social Security (by having earned 40 quarters of coverage), you are eligible for premium-free Part A. Without 40 quarters of coverage, one may still get Medicare by paying a premium for Part A. If you have questions about your eligibility for Medicare, or if you want to apply for Medicare, call the Social Security Administration at 1-800-772-1213 (1-800-325-0778 TTY). You can learn more about applying for Medicare at www.socialsecurity.gov.

How Do I Enroll in Medicare?

Automatic Enrollment: If you are already getting Social Security or Railroad Retirement benefits when you turn 65, you do not have to apply for Medicare. You are enrolled automatically in both Part A and Part B and your Medicare card is mailed to you about three months before your 65th birthday. If you receive Social Security Disability benefits, you will automatically get a Medicare card in the mail after you have received Social Security Disability benefits for 24 consecutive months.

Applying for Medicare Part A: Those eligible for premium-free Part A can enroll in Medicare Part A at any time, and coverage can be retroactive up to six months. Those who need to pay a premium for Part A (don't have 40 quarters of coverage through Social Security) can only enroll January 1-March 31, with coverage effective July 1.

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聯邦醫療保險 (MEDICARE)

聯邦醫療保險是針對 65 歲或以上老人、某些未達此年齡的殘障人士及腎臟衰竭患者而設的全國性醫療保險計畫。含有四部分：

- 住院保險 (A 部分)。
- 醫療保險 (B 部分)。
- 聯邦醫療保險優勢計畫 (C 部分 — HMO、PPO、特殊需求計畫、醫療儲蓄帳戶和私營付費服務計畫)。聯邦醫療保險優勢計畫提供住院和醫療保險。參加聯邦醫療保險優勢計畫者將經由該項私營計畫取得保險，而非透過「聯邦醫療保險原始計畫」。
- 處方藥保險 (D 部分)。參加聯邦醫療保險優勢計畫者若需要藥品保險，必須透過該計畫取得此項保險。參加「聯邦醫療保險原始計畫」者若需要藥品保險，則應參加單行的 D 部分計畫。

誰有資格申請參加聯邦醫療保險？

年滿 65 歲或以上者，並且是美國公民或定居至少連續五年的永久居民即具備資格。65 歲以下者若領取社會安全殘障保險金 (SSDI) 達 24 個月，有資格參加保險；肌萎縮性脊髓側索硬化症 (ALS) 患者 (即漸凍人) 在領取社會安全殘障保險金的首月即符合資格。末期腎臟疾病 (ESRD) 患者皆有資格參加聯邦醫療保險，不受年齡限制。勞工、以及勞工的配偶 (包括同性配偶) 或子女可能有資格參加聯邦醫療保險，視勞工的工作記錄而定，若其因永久性腎臟衰竭而持續接受洗腎或曾進行腎臟移植，即使家庭中無其他成員擁有聯邦醫療保險，亦得以參加。若您或配偶 (包括同性配偶) 擁有社會安全保險 (已累積 40 個工作季點)，便有資格免付保費取得 A 部分保險計畫。若尚未取得 40 個工作季點，仍可以自行支付 A 部分保費而取得聯邦醫療保險。如對自己參加聯邦醫療保險的資格有疑問，或是有意申請聯邦醫療保險，請致電社會安全局 1-800-772-1213 (1-800-325-0778 聽障專線)。欲進一步瞭解如何申請聯邦醫療保險，請至 www.socialsecurity.gov。

如何加入聯邦醫療保險？

自動加入：若您在年滿 65 歲時已開始領取社會安全福利金或鐵道退休福利金，則無須自己申請聯邦醫療保險。您將自動加入 A 部分和 B 部分，而且您的聯邦醫療保險卡將在您的 65 歲生日之前 3 個月寄送給您。若您領取社會安全殘障福利金，在連續 24 個月領取社會安全殘障福利金之後，聯邦醫療保險卡將自動寄送給您。

申請聯邦醫療保險 A 部分：符合 A 部分免保費資格者可隨時加入聯邦醫療保險 A 部分，而且保障可往回追溯最多 6 個月。至於必須自行支付 A 部分保費者 (尚未取得 40 個社會安全工作季點)，只能在 1 月 1 日至 3 月 31 日期間登記加入，保障自 7 月 1 日起生效。

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Applying for Medicare Part B: If you are not receiving Social Security or Railroad Retirement benefits when you turn 65, you have a seven-month Initial Enrollment Period (IEP) in which to enroll in Medicare. You can enroll by contacting the Social Security Administration (SSA) three months before you turn 65, as well as the month in which you turn 65 and the three months that follow. If you enroll in the three months prior to your birthday, your Medicare coverage will be effective the first of the month of your birthday. If you enroll in the month of your birthday, your coverage will be effective the first of the following month. If you enroll in the month after your birthday, your coverage will be effective two months later. If you enroll two or three months after your birthday, your coverage will be effective three months later.

If you do not enroll during this seven-month period, you will have to wait to enroll during the next general enrollment period which is January 1 to March 31 of each year, but Part B coverage will not start until July. If you do not enroll during the initial enrollment period and do not have other coverage through an active employer of you or your spouse, you will face a higher premium as a penalty for late enrollment. The penalty for late enrollment is 10% for every 12 months of non-enrollment in Part B.

Actively Employed and Medicare Eligible: If you or your spouse are actively employed and have health insurance through the employer, you may not need to enroll in Medicare Part B when you first become eligible; contact the employer as to whether you are required to enroll in Part B. You may wish to enroll in Part A regardless because there is no premium for this coverage. Refer to the section on Medicare as Secondary Payer (see page 12) for more information.

Medicare Part A Benefits

Medicare Part A covers inpatient hospital care, skilled nursing facility care, home health care, and hospice care.

Medicare Advantage enrollees get their Part A benefits through their plan and cannot submit bills to Medicare.

Inpatient Hospital Care: Medicare pays for up to 90 days of medically necessary care in either a Medicare-certified general or psychiatric hospital during a benefit period. A **benefit period** starts when you are admitted to the hospital and continues until you have been out of the hospital and skilled nursing facility for 60 consecutive days. After one benefit period has ended, another one will start whenever you next receive inpatient hospital care. Medicare beneficiaries have 60 lifetime reserve days after day 90 of each benefit period.

Medicare will pay for a lifetime maximum of 190 days of inpatient psychiatric care provided in a psychiatric hospital. After 190 days have been used, Medicare will pay for more inpatient psychiatric care only in a general hospital.

申請聯邦醫療保險 B 部分：若您年滿 65 歲時尚未領取社會安全福利金或鐵道退休福利金，則有 7 個月的首次參加期 (IEP) 可登記加入聯邦醫療保險。您可以在年滿 65 歲之前 3 個月、以及年滿 65 歲的當月和之後的 3 個月內，聯絡社會安全局 (SSA) 登記加入。若您在生日之前 3 個月登記加入，您的聯邦醫療保險的保障將自您生日所在月份的第一天生效。若您在生日當月登記加入，您的保障將自下一個月的第一天生效。若您在生日之後的 1 個月登記加入，您的保障將自 2 個月後生效。若您在生日之後的 2 或 3 個月登記加入，您的保障將自 3 個月後生效。

若您在這 7 個月期間未登記加入，將必須等到下一次的一般參加期才能登記加入，一般參加期為每年 1 月 1 日至 3 月 31 日，不過 B 部分保險將至 7 月才開始生效。若您未在首次參加期期間登記加入，亦未經由您本人或配偶的現有雇主投保其他保險，您將因延遲登記而面臨繳付高保費作為罰金。未登記加入 B 部分，每 12 個月的延遲登記罰金為 10%。

受雇就業與聯邦醫療保險資格：若您或配偶現為受雇就業並由雇主處取得醫療保險，當您初次符合資格時，可能無須登記加入聯邦醫療保險 B 部分；請聯絡雇主查詢您是否需要登記加入 B 部分。無論如何，您可能有意加入 A 部分，因為此項保險無須保費。請參考「聯邦醫療保險為副保險」(第 12 頁) 的部分以瞭解詳情。

聯邦醫療保險 A 部分的保險賠付

聯邦醫療保險 A 部分承保住院治療、專業護理設施、居家護理和安寧療護。

聯邦醫療保險優勢計畫的參加者是透過該計畫取得 A 部分的保險賠付獲得保障，而非將帳單遞交聯邦醫療保險。

住院治療：於權益期間在聯邦醫療保險認可的綜合醫院或精神病院接受必要治療，聯邦醫療保險將賠付最多達 90 天。**權益期**從您辦理住院開始，算至您連續 60 天未在醫院或專業護理設施接受住院治療為止。一段權益期結束後，無論何時您再次接受住院治療，即開始另一段權益期。聯邦醫療保險受益人在每一段權益期的第 90 天之後，都有 60 天終身儲備期 (lifetime reserve days)。

對於在精神病院所提供的住院精神病治療，聯邦醫療保險將賠付的終身儲備期最高期限為 190 天。當終身儲備期 190 天用罄之後，聯邦醫療保險將僅賠付受益人在綜合醫院接受住院精神病治療。

Medicare Part A helps pay for a semi-private room, meals, regular nursing services, rehabilitation services, drugs, medical supplies, laboratory tests and X-rays. You are also covered for use of the operating and recovery rooms, mental health services, intensive care and coronary care units, and all other medically necessary services and supplies.

Most people are eligible for premium-free Part A because they or their spouse have at least 40 quarters of coverage with Social Security. Those who do not have 40 quarters of coverage with Social Security can pay a monthly premium for Part A coverage. In 2016, if you have less than 30 quarters of Social Security coverage, your Part A premium will be \$411 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium will be \$226 per month. For low-income beneficiaries who qualify for the QMB Medicare Savings Program (see page 35), QMB may also be able to pay the Part A premium for those who do not qualify for premium-free Part A.

Part A Cost Sharing in 2016:

- Deductible: \$1,288 per benefit period
- Days 61-90 of an inpatient stay: \$322 per day
- Lifetime Reserve Days: \$644 per day

Skilled Nursing Facility Care: If after being discharged after a three-day minimum stay as an inpatient in a hospital (not counting the day of discharge), you need to go to a skilled nursing facility, Medicare will help pay for your care for up to 100 days in a benefit period. (Days under "observation" status in a hospital are covered under Medicare Part B, and are not counted towards the three-day qualifying minimum stay for SNF coverage.) Medicare Part A pays the full cost of covered services for the first 20 days. All covered services for the next 80 days are paid for by Medicare except for a daily co-payment amount of \$161 in 2016. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day. **Note: a stay in a skilled nursing facility is not long term care.**

Home Health Care: If you are homebound and require skilled care for an injury or illness, Medicare can pay for care provided in your home by a home health agency. A prior stay in the hospital is not required to qualify for home health care, and you do not have to pay a deductible for home health services. Medicare Part A pays the entire bill for covered services for as long as they are medically reasonable and necessary. The services may be provided on a part-time or intermittent basis, not full-time. Coverage is provided for skilled care, including skilled nursing care, physical, occupational, and speech therapy. If you are receiving skilled care, you may also qualify for other services, such as a home health aide and medical social workers.

Information on Mandatory Medicaid Managed Long Term Care (MLTC) for dual eligibles (have both Medicare and Medicaid) can be found on page 41.

Hospice Care: Medicare beneficiaries who are terminally ill you can elect to receive hospice care rather than regular Medicare benefits. Hospice care emphasizes providing comfort and relief from pain. The care can be at home or as an inpatient, and includes many services usually not covered by Medicare, such as homemaker services, counseling, and certain prescription drugs.

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聯邦醫療保險 A 部分會幫助支付雙人病房、膳食、普通護理服務、康復服務、藥品、醫療設施、醫療檢驗和 X 光。您還會得到下列承保項目：使用手術室和恢復室、心理健康服務、加護病房和心臟重症加護病房，以及所有其他的必要醫療服務和醫療用品。

只要本人或配偶累積至少 40 個社會安全工作季點，多數人都有資格獲得免保費的 A 部分計畫。如果尚未取得 40 個社會安全工作季點，可支付月保費以取得 A 部分保險。在 2016 年，若您的社會安全保險少於 30 個工作季點，A 部分保費將是每月 \$411。若您的社會安全保險累積了 30 至 39 個工作季點，A 部分保費將是每月 \$226。至於有資格申請 QMB 聯邦醫療保險免保費計畫（請見第 35 頁）者，QMB 或許也能為無資格獲得免保費 A 部分者支付 A 部分的保費。

2016 年 A 部分的費用分攤：

- 自付額：每一段權益期為 \$1,288
- 住院治療第 61 天至 90 天：每天 \$322
- 終身儲備期：每天 \$644

專業護理設施：以住院病人身份在醫院住院至少三天（不含出院日），若出院後必須前往專業護理設施，聯邦醫療保險將協助支付權益期內的護理費用，最多達 100 天。（在醫院處於「觀察」狀態的日子由聯邦醫療保險 B 部分承保，不計入專業護理設施保險合格規定的至少三天住院期內。）聯邦醫療保險 A 部分賠付承保服務項目首 20 天的全部費用。之後 80 天所有承保服務項目的費用，在 2016 年將須扣除每天 \$161 的共付額後，再由聯邦醫療保險支付。若您在權益期內所需要的醫療護理超過 100 天，從第 101 天開始的全部費用將由您自行負擔。**註：住在專業護理設施並非長期護理。**

居家護理：若您返家但因傷病而需要專業護理，由居家護理機構在您家中提供的護理可由聯邦醫療保險支付。無須先住院即可符合居家護理賠付的資格，而且無須為居家護理服務支付自付額。只要承保服務為合理且必要的醫療措施，聯邦醫療保險 A 部分即會賠付全部帳款。這些服務得以部分時間或間歇性方式提供，而非全日性的。專業照護可得到保險賠付，包括：專業護理，物理、職能和言語治療。若您是接受專業照護，可能也有資格接受其他服務，例如居家保健助理和醫療社工等服務。

具雙重資格者（擁有聯邦醫療保險和醫療補助）的關於強制性醫療補助管理的長期護理 (MLTC) 的資訊載於第 41 頁。

安寧療護：聯邦醫療保險受益人若患有絕症，可以選擇接受安寧療護，而非一般的聯邦醫療保險賠付。安寧療護強調提供舒適環境並減輕病痛。這類護理可以是在家提供或是住院，並且包含聯邦醫療保險通常並不承保的許多服務，例如：管家家事服務、諮詢和某些處方藥。

請致電 311 洽詢 HIICAP

Medicare Part B Benefits

Part B of Medicare pays for a wide range of medical services and supplies, but most important is that it helps pay for doctor bills. The medically necessary services of a doctor are covered whether the care is at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. Part B also helps pay for:

- Outpatient hospital services
- Outpatient mental health care
- Blood, after the first 3 pints
- Ambulance transportation
- Physical, speech & occupational therapy
- Preventive & Screening tests
- Flu, pneumonia & hepatitis B vaccines
- Injectibles
- Artificial prostheses
- X-rays & lab tests
- Durable medical equipment
- Medical supplies

Medicare Advantage enrollees get their Part B benefits through their plan and cannot submit bills to Medicare.

What Do You Pay Under Part B?

Medicare Part B beneficiaries are responsible for paying a monthly premium, an annual deductible, and a coinsurance for most services.

In 2016 the monthly premium is \$121.80. However, because there is no Social Security Cost of Living Adjustment (COLA) for 2016, most Medicare beneficiaries will be "held harmless" from a premium increase and will continue to pay the 2015 premium of \$104.90. Individuals and couples with annual incomes over \$85,000 and \$170,000, respectively, will be responsible for higher premiums. See page 63 for more information.

The following beneficiaries will be responsible for the 2016 monthly premium of \$121.80:

- Those who first enroll in Part B in 2016; and
- Those who are not yet collecting Social Security benefits, even though they may have had Part B in 2015.

You are responsible for paying the annual Part B deductible. After meeting the deductible, Medicare pays for 80% of Medicare-approved charges. You are responsible for paying the other 20%, referred to as the Medicare coinsurance.

Medicare covers physical and speech therapy services up to \$1,960 per year and occupational services up to \$1,960 per year in 2016. The cap includes all therapy done in the office, home (if not receiving Medicare-covered home health care services), and care in the outpatient department of a hospital. There are certain exceptions which allow the cap to be extended, such as for more complicated medical conditions. You can check with your physical therapist to see if you qualify for an exception.

Medicare Supplement (Medigap) Insurance helps Medicare beneficiaries pay their share of the costs not covered by Medicare. These policies fill in the "gaps" of Medicare's reimbursement, but only for the approved services under Medicare coverage. See page 14 for information on Medigap policies.

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險 (MEDICARE) B 部分的保險賠付

聯邦醫療保險 B 部分支付範圍廣泛的醫療服務和用品，但最重要的是它能幫助支付醫生費用。醫療上必要的醫生服務都有承保，不論照護是於住家、醫生的辦公室、診所、療養院或醫院之中提供。B 部分還幫助支付：

- 醫院門診服務
- 心理健康門診治療
- 最初 3 品脫之後的血液
- 救護車運送
- 物理、言語及職能治療
- 預防性與篩檢檢驗
- 流感、肺炎及 B 型肝炎疫苗
- 注射
- 義肢
- X 光及醫療檢驗
- 耐久性醫療器材
- 醫療用品

聯邦醫療保險優勢計畫的參加者是透過該計畫取得 B 部分的保險賠付獲得保障，而非將帳單遞交聯邦醫療保險。

您在 B 部分需要支付的費用為何？

聯邦醫療保險 B 部分受益人須支付月保費、年度自付額以及大部分服務的共保額。

2016 年月保費為 \$121.80。但是，由於 2016 年不進行社會安全福利金生活成本調整 (COLA)，大部分聯邦醫療保險受益人將不受保費增加的影響，而繼續支付 2015 年的保費 \$104.90。年收入超過 \$85,000 的個人和年收入超過 \$170,000 的夫婦，將需要支付更高的保費。請見第 63 頁瞭解詳情。

以下受益人需要支付 2016 年保費為 \$121.80：

- 2016 年第一次加入 B 部分的人；以及
- 即便在 2015 年加入聯邦醫療保險 B 部分但未領取社會安全福利金的人。

您有責任支付 B 部分的年度自付額。繳交自付額之後，對於聯邦醫療保險所核准的費用，聯邦醫療保險將賠付 80%。您有責任支付剩餘的 20% 費用，此即聯邦醫療保險共保額。

在 2016 年，聯邦醫療保險對物理和言語治療服務的保險賠付上限為每年 \$1,960，對職能服務賠付的上限為每年 \$1,960。上限適用於在私人診所或家中接受的一切治療（若無聯邦醫療保險所承保的居家護理），以及在醫院門診部中的護理。某些特例狀況可讓上限提高，比如更加複雜的病症。您可以向您的物理治療師核實，以瞭解您是否符合特例狀況的資格。

聯邦醫療保險補充保險 (Medigap) 協助聯邦醫療保險受益人支付聯邦醫療保險不賠付的分攤費用部分。這些補充性保險能彌補聯邦醫療保險償款的「差額」，但僅限於依聯邦醫療保險承保項目所核准的服務。關於醫療補充保險的規定請參見第 14 頁。

請致電 311 洽詢 HIICAP

How Much Can Providers Charge for Services?

There are different relationships that doctors and medical providers can choose to have with the Medicare program. What category the provider is in affects how much you will pay for their services. Providers can be "Participating" providers, "Non-Participating" providers, or they can "Opt Out" of the Medicare program. Below are descriptions of each of these scenarios.

- If a provider is a "**Participating**" provider, they will always accept the Medicare allowed amount as payment in full (Medicare pays 80% and the beneficiary pays 20%). If you want to find out whether a provider is participating, you can ask, "Is the doctor a participating provider in the Medicare program?" It is best to ask this question when making an appointment, and also to confirm this information at the time of the appointment.
- They can be "**Non-Participating**" providers. Non-participating providers still have a relationship with the Medicare program; how this category differs from "Participating" providers is how much they can charge to see a Medicare beneficiary. Non-participating providers can either "**accept assignment**" or "**not accept assignment**" on each claim. If you learn that a provider is Non- Participating, ask, "Will the doctor accept assignment for my claim?"
 - If a provider **accepts assignment**, he or she will accept the amount Medicare approves for a particular service and will not charge you more than the 20% co-insurance (for most services).
 - If a provider does **not accept assignment**, the charges are subject to a "Limiting Charge," which is an additional charge over the Medicare- approved amount. The Limiting Charge that applies for office visits and home visits is 15%. For most other services provided by physicians in New York State, the Limiting Charge is 5%.

TIP: To locate providers in the Medicare program, visit www.medicare.gov or call 1-800-MEDICARE.

- Providers can "**Opt Out**" of the Medicare program. Medicare providers have the right to officially "opt out" of Medicare for a two-year period and enter into a private written contract with any Medicare patient who seeks their treatment. The doctor will set a fee for each specific service and the patient agrees to pay the costs understanding that Medicare will not pay that doctor or reimburse the patient. A Medicare supplement policy or "Medigap" will not pay any of these costs either. The Medicare beneficiary is still covered by Medicare for services by other providers. "Opting Out" is different from providers who do not accept Medicare Assignment where the set fees and reimbursements are still controlled by Medicare.

醫療業者可就服務項目收取多少費用？

醫生與醫療業者可選擇與聯邦醫療保險計畫之間存在不同的關聯。醫療業者選擇的類別會影響您對他們的服務所需要支付的款項。醫療業者可以「參與」、「不參與」或「退出」聯邦醫療保險計畫。以下是各個情境的描述。

- 若醫療業者「**參與**」，他們將始終接受聯邦醫療保險所容許的金額作為收取的全額（聯邦醫療保險支付 80%，受益人支付 20%）。若您想知道醫療業者是否「參與」，您可以詢問：「醫生是否參與聯邦醫療保險計畫？」最好在作出預約時詢問，也可以在就診時確認此資訊。
- 醫療業者可以「**不參與**」。不參與的醫療業者仍可以與聯邦醫療保險計畫存在關聯；這類醫療業者與「參與」醫療業者的不同之處在於他們向聯邦醫療保險受益人的收費。不參與的醫療業者可針對每項理賠「**接受費用安排**」或「**不接受費用安排**」。若您知悉醫療業者不參與計畫，則可以問：「醫生是否對我的理賠接受費用安排？」
 - 若醫療業者**接受費用安排**，他或她將接受聯邦醫療保險就特定服務所核准的費用金額，而且對您的收費不得超過 20% 的共保額（就大多數服務而言）。
 - 若醫療業者**不接受費用安排**，則費用將受到「限制收費」的約束，此為在聯邦醫療保險所核准的金額之外的額外收費。適用於診所和居家護理的限制收費為 15%。對於在紐約州由醫生提供的大多數其他服務，限制收費為 5%。

要領：為找尋聯邦醫療保險計畫的醫療業者，請造訪 www.medicare.gov 或致電 1-800-MEDICARE。

- 醫療業者可「**退出**」聯邦醫療保險計畫。聯邦醫療保險的醫療業者有權正式「退出」聯邦醫療保險，為期兩年，並與任何尋求其治療的聯邦醫療保險病患訂立私人書面契約。醫生將為每項服務設定收費，而病人同意支付費用，並且明白聯邦醫療保險不會付款予醫生或償款予病人。聯邦醫療保險的補充性保險 (Medigap) 也不會支付任何這類費用。聯邦醫療保險受益人接受其他醫療業者所提供的服務時，仍然受到聯邦醫療保險的保障。「退出」和醫療業者不接受聯邦醫療保險的費用安排不同，那些服務項目的收費和償款仍是由聯邦醫療保險控制。

Advance Beneficiary Notice of Non-Coverage

Sometimes Medicare may not cover a service because it is not considered to be “medically necessary.” In these cases, the health care provider must provide, in writing, the “Advance Beneficiary Notice of Non-coverage (ABN)” indicating the service that they believe Medicare will not pay for. The form must contain the service in question; the date of the service; a specific reason why the service may not be paid for by Medicare; and a place for the beneficiary to sign as proof that they understand and accept responsibility to pay for the service. The beneficiary is not responsible to pay unless he or she signed a valid ABN. The ABN does not apply to services never covered by Medicare (i.e. hearing aids), which are always the beneficiary’s responsibility. Providers must use an ABN for physical, speech and occupational therapy services. Without a signed ABN, the beneficiary is not responsible for charges in excess of the cap for these services (see following page for a sample ABN).

Medicare Summary Notice

For assigned claims, a Medicare Summary Notice (MSN) will be mailed quarterly to each Medicare beneficiary for whom a Part A and/or Part B claim was submitted by a provider. For unassigned claims, a MSN will be mailed as the claims are processed, along with a check to the beneficiary, if the beneficiary has pre-paid for the service. Beneficiaries will be able to utilize the MSN for reimbursement from a Medigap policy. The MSN also contains information on how you can appeal Medicare claim denials. Beneficiaries can also access their MSNs electronically at www.mymedicare.gov. One can request to receive the MSN in Spanish by calling 1-800-MEDICARE.

To view a sample MSN for Medicare Parts A and B, as well as an explanation for reading the MSN, visit www.medicare.gov/pubs/pdf/SummaryNoticeA.pdf and www.medicare.gov/pubs/pdf/SummaryNoticeB.pdf.

受益人未受保項目事前通知

有時某種服務不在聯邦醫療保險的賠付範圍之內，因為該服務被認為無「醫療必要」。若有這種情況，醫護業者必須以書面方式提供「受益人未受保項目事前通知 (ABN)」，說明聯邦醫療保險將不會賠付的服務項目。該通知必須包含有疑問的服務項目；服務日期；該服務不能獲得聯邦醫療保險賠付的特定原因；並要求受益人簽名以證明他們明白並同意自行付費接受服務。除非受益人已簽署有效的 ABN，否則他或她不負責付款。ABN 不適用於聯邦醫療保險從不承保的、一直由受益人負責的服務項目（如助聽器）。醫療業者必須使用 ABN 以進行物理、言語及職能治療服務。若未簽署 ABN，受益人便無須為這類服務超出上限的費用負責（請見下頁的 ABN 範例）。

聯邦醫療保險摘要通知

對於已受理的索賠，聯邦醫療保險受益人將於每一季收到郵寄的聯邦醫療保險摘要通知 (MSN)，其 A 部分和/或 B 部分理賠申請已由醫療業者送出。至於尚未受理的索賠，聯邦醫療保險摘要通知將於理賠申請處理後寄出，若受益人已為該服務預付費用，受益人將一併收到支票償款。受益人可用聯邦醫療保險摘要通知來向醫療補充保險要求償款。聯邦醫療保險摘要通知還附有說明聯邦醫療保險理賠申請遭駁回時該如何申訴的資訊。受益人也可以造訪 www.mymedicare.gov，用電子方式取得聯邦醫療保險摘要通知。可致電 1-800-MEDICARE 要求收取西班牙語的 MSN。

欲查看聯邦醫療保險 A 部分和 B 部分的聯邦醫療保險摘要通知範例，以及聯邦醫療保險摘要通知的閱讀說明，請造訪 www.medicare.gov/pubs/pdf/SummaryNoticeA.pdf 和 www.medicare.gov/pubs/pdf/SummaryNoticeB.pdf。

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.

Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/> OPTION 2. I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
<input type="checkbox"/> OPTION 3. I don't want the D. _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

A. 通知者:

B. 病人姓名:

C. 身份證號碼:

受益人未受保項目事前通知 (ABN)

註: 如果聯邦醫療保險不賠付下列的 D. _____, 您可能必須支付費用。

聯邦醫療保險不會賠付所有的項目, 即便是您自己或醫護業者有充分理由認為需要某些醫護服務。聯邦醫療保險可能不會賠付下列的 D. _____。

D.	E. 聯邦醫療保險不賠付的理由:	F. 估計費用

您需要馬上採取的措施:

閱讀本通知, 才能對自己的醫療護理做出知情決策。

閱讀完畢後, 向我們提出您可能會有的任何問題。

從下方的選項中選擇是否要接受上述的 D. _____。

註: 如果選擇選項 1 或 2, 我們可能協助您利用您可能擁有的任何其他保險, 但是聯邦醫療保險不能要求我們這麼做。

G. 選項: 只能勾選一項。我們不能為您勾選。
<input type="checkbox"/> 選項 1. 我要接受上述的 D. _____。您可以要求馬上付款, 但是我也希望聯邦醫療保險能收到帳單, 以便對賠付做出正式決定, 並以聯邦醫療保險摘要通知 (MSN) 寄送給我。我理解, 如果聯邦醫療保險不賠付, 我要負責支付費用, 但是 我可以向聯邦醫療保險上訴 , 只要遵照聯邦醫療保險摘要通知上的指示即可。如果聯邦醫療保險賠付, 我所支付的費用將在扣除共付額或自付額之後被退款。
<input type="checkbox"/> 選項 2. 我要接受上述的 D. _____, 但不要向聯邦醫療保險收費。由於我有責任支付費用, 可以要求我馬上付款。 如果未向聯邦醫療保險收費, 我不能提出上訴。
<input type="checkbox"/> 選項 3. 我不想接受上述的 D. _____。我理解, 這項選擇表示我不必負責支付費用, 而且 我不能上訴以試探聯邦醫療保險是否會賠付。

H. 其他資訊:

本通知僅提供我們的看法, 並非聯邦醫療保險的正式決定。如果您對本通知或聯邦醫療保險的計費有其他疑問, 請致電 **1-800-MEDICARE** (1-800-633-4227/聽障專線: 1-877-486-2048)。

在下方簽名即表示您已收到並理解本通知。您也收到一份副本。

I. 簽名:	J. 日期:
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根據 1995 年減少文書作業法 (Paperwork Reduction Act of 1995), 除非顯示有效的 OMB 管理號碼, 否則不必理會資訊收集表。此份資訊收集表的有效 OMB 管理號碼為 0938-0566。填寫此份資訊收集表所需的時間估計為每份平均 7 分鐘, 包括查閱說明、搜尋現有的資料資源、蒐集所需資料, 以及填寫並檢查資訊收集表。如果您對估計時間的正確性有意見, 或欲對改進本表格提供建議, 請寫信至: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850。

MEDICARE PREVENTIVE SERVICES

Medicare covers nearly all preventive services at 100%, not subject to the Part B deductible and/or 20% coinsurance. Medicare provides coverage for the following preventive services to help you stay healthy:

Alcohol Misuse Screening and Counseling	Medicare covers an annual screening for alcohol misuse. For those who screen positive, Medicare will also cover up to four brief, face-to-face behavioral counseling interventions annually.
Behavioral Therapy for Cardiovascular Disease (CVD)	Medicare covers one face-to-face CVD risk reduction visit annually. The visit encourages aspirin use, screening for high blood pressure, and behavioral counseling to promote a healthy diet.
Bone Mass Measurements	Procedures to identify bone loss, or determine bone density are covered every 24 months. Women at risk for osteoporosis or who are receiving osteoporosis drug therapy and persons with spine abnormalities qualify for these procedures.
Cardiovascular Screening	Medicare covers cardiovascular screenings that check cholesterol and other blood fat (lipid) levels once every 5 years.
Colorectal Cancer Screening	Fecal Occult Blood Test: covered once every 12 months Flexible Sigmoidoscopy: covered once every 48 months Colonoscopy: covered once every 24 months if you are at higher risk for colon cancer. If you are not at higher risk it is covered once every 10 years but not within 48 months of a screening flexible sigmoidoscopy. Barium Enema: this can be substituted for a flexible sigmoidoscopy or colonoscopy; you pay 20% of the Medicare-approved amount. Cologuard™ test: covered once every 3 years for people with Medicare who are between 50 and 85 years old; show no signs or symptoms of colorectal disease; and are at average risk of developing colorectal cancer.
Depression Screening	Medicare covers depression screenings by your primary care doctor once every 12 months.
Diabetes Services	Diabetes screenings for those at higher risk covered at 100%. Coverage for glucose monitors, lancets, test strips and diabetes self-management training for both insulin and non-insulin dependent of those diagnosed with diabetes. You pay 20% of the Medicare-approved amount after the Part B deductible.
Glaucoma Screening	People at high risk for glaucoma, including people with diabetes or a family history of glaucoma, are covered once every 12 months. You pay 20% of the Medicare-approved amount after the Part B deductible.
Hepatitis C Screening	Medicare covers one Hepatitis C screening test for people born between 1945-1965, and a yearly repeat screening for certain people at high risk.
HIV Screening Test	Covered once every 12 months for any beneficiary who requests the test.
Lung Cancer Screening	Medicare covers lung cancer screening every 12 months for people who are age 55-77 and are either a current smoker or have quit smoking within the last 15 years.

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險預防性保健服務

幾乎全部的預防性保健服務都可以獲得聯邦醫療保險 100% 賠付，不再受到 B 部分自付額和/或 20% 共保額的限制。聯邦醫療保險承保下列的預防性保健服務，以幫助您保持健康：

酗酒檢測與諮商輔導	聯邦醫療保險承保每年進行一次酗酒檢測。對於篩檢呈陽性反應者，聯邦醫療保險每年亦將對最多四次簡短的面對面行為介入輔導提供賠付。
心血管疾病 (CVD) 的行為治療	聯邦醫療保險承保每年進行一次面對面的降低心血管疾病風險門診。該門診會鼓勵使用阿斯匹靈、進行高血壓篩檢，並且提供行為諮商以提倡膳食健康。
骨質密度檢查	用以判斷骨質流失或骨質密度的檢查程序，每 24 個月可進行一次。有骨質疏鬆症危險或正在接受骨質疏鬆症藥物治療的婦女，以及患有脊椎異常的人士，將有資格接受這類檢查程序。
心血管篩檢	聯邦醫療保險賠付的心血管篩檢包括每 5 年檢查一次膽固醇和其他血脂肪含量。
大腸癌篩檢	糞便潛血檢查：每 12 個月可檢查一次 軟式乙狀結腸鏡檢查：每 48 個月可檢查一次 結腸鏡檢查：若屬於患上結腸癌的高危險群可每 24 個月檢查一次。若非屬於高危險群則是每 10 年檢查一次，但不得在做過軟式乙狀結腸鏡檢查後的 48 個月之內進行。 鉭劑灌腸攝影：可用以取代軟式乙狀結腸鏡檢查或結腸鏡檢查；須支付聯邦醫療保險核准金額之 20%。 Cologuard™ 測試：為下列條件者承保每 3 年一次的測試：50 歲至 85 歲參與聯邦醫療保險者；並無顯示結直腸疾病的徵兆或症狀；以及處於患結腸直腸癌的平均風險。
憂鬱症篩檢	聯邦醫療保險承保由主診醫生所進行的憂鬱症篩檢，每 12 個月可檢查一次。
糖尿病服務	高危險人士的糖尿病篩檢為 100% 賠付。承保範圍包括：血糖監測器、採血針、試紙條，以及診斷出患有糖尿病而不論是否需要倚賴胰島素者的糖尿病自我管理訓練。在扣除 B 部分自付額後支付聯邦醫療保險核准金額之 20%。
青光眼檢查	青光眼高危險人士，包括患有糖尿病或有青光眼家族病史者，每 12 個月可檢查一次。在扣除 B 部分自付額後支付聯邦醫療保險核准金額之 20%。
丙肝篩檢	聯邦醫療保險為 1945-1965 年出生的人承保一次丙肝篩檢，並為特定的高風險人士承保每年一次的複檢。
愛滋病毒篩檢測試	任何要求檢測的受益人每 12 個月可進行一次。
肺癌篩檢	聯邦醫療保險為 55-77 歲的人以及現在還抽煙或在過去 15 年內戒煙的人每 12 個月承保一次肺癌篩檢。

請致電 311 洽詢 HIICAP

Mammogram Screening	One baseline mammogram is covered between ages 35 and 39. All women with Medicare, aged 40 and older, are provided with coverage for a screening mammogram every 12 months. A diagnostic mammogram is covered at any time there are symptoms of breast cancer. The diagnostic mammogram is subject to the Part B deductible and 20% co-insurance.
Medical Nutrition Therapy	Medicare covers 3 hours of one-on-one counseling services the first year, and 2 hours each year after that for beneficiaries with diabetes or kidney disease.
Obesity Screening and Counseling	If you have a body mass index of 30 or more, Medicare covers a dietary assessment as well as intensive behavioral counseling and behavioral therapy.
Pap Test and Pelvic Exam	A pap test, pelvic exam and clinical breast exam are covered every 24 months, or once every 12 months for women at higher risk for cervical or vaginal cancer. All women with Medicare are covered.
Physical Exam	An initial preventive physical exam will be covered during the first twelve months of Medicare Part B enrollment. Also, an annual wellness visit is covered for all people with Medicare Part B, but not within 12 months of the initial exam.
Prostate Cancer Tests	<u>Digital Rectal Examination</u> : Covered once every 12 months for men aged 50 and older. You pay 20% of the Medicare-approved amount after the Part B deductible. <u>Prostate Specific Antigen (PSA) blood screening test</u> : Covered once every 12 months for men aged 50 and older.
Sexually Transmitted Infections (STIs) Screening and High-Intensity Behavioral Counseling (HIBC) to prevent STIs	Medicare covers screening for Chlamydia, gonorrhea, syphilis and hepatitis B, as well as high intensity behavioral counseling (HIBC) to prevent STIs. The screening is for up to two individual 20 to 30 minute, face to face counseling sessions annually for those at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting.
Smoking Cessation Counseling	Counseling to stop smoking. Medicare will cover up to 8 face-to-face visits during a 12-month period for beneficiaries who use tobacco.
Vaccinations/Shots	<u>Flu</u> : Covered once per flu season. <u>Pneumonia</u> : Usually only needed once in a lifetime. A different, second shot, is covered 12 months after you get the first shot. <u>Hepatitis B</u> : Covered if at high or intermediate risk.

乳房透視檢查	35 歲至 39 歲可進行一次基本乳房透視。擁有聯邦醫療保險的 40 歲以上婦女，每 12 個月可做一次乳房透視檢查。有乳癌症狀出現時，不論何時所做的診斷性乳房透視都在承保範圍內。診斷性乳房透視受到 B 部分自付額和 20% 共保額限制。
醫療營養治療	對於患有糖尿病或腎臟疾病的受益人，聯邦醫療保險的賠付包括第一年 3 小時的一對一諮詢輔導服務，其後則是每年 2 小時。
肥胖症篩檢與諮詢輔導	身體質量指數若達 30 或以上，膳食評估、密集式行為輔導以及行為治療可獲聯邦醫療保險賠付。
子宮頸抹片檢查和骨盆腔檢查	每 24 個月可進行一次子宮頸抹片檢查、骨盆腔檢查和臨床乳房檢查，屬於子宮頸癌或陰道癌高危險群的婦女可每 12 個月做一次檢查。擁有聯邦醫療保險的所有婦女都受到保障。
體檢	加入聯邦醫療保險 B 部分之後的 12 個月內可進行首次預防性體檢。另外，所有加入聯邦醫療保險 B 部分的人士，每年都可以做一次健康檢查，但在首次體檢後的 12 個月之內不得進行。
前列腺癌檢查	<u>肛門指診</u> ：50 歲以上男性可以每 12 個月檢查一次。在扣除 B 部分自付額後支付聯邦醫療保險核准金額之 20%。 <u>前列腺特異抗原 (PSA) 血液檢測</u> ：50 歲以上男性每 12 個月可做一次。
性傳播疾病感染 (STI) 篩檢與預防 STI 的高度密集式行為輔導 (HIBC)	聯邦醫療保險承保對衣原體感染、淋病、梅毒和 B 型肝炎的篩檢，以及預防性傳播疾病感染的高度密集式行為輔導 (HIBC)。對於可能罹患 STI 的高危險群，每年可以進行最多兩次個別的 20 至 30 分鐘面對面輔導，前提是此項服務必須由主診醫生轉介，並且是由符合聯邦醫療保險資格的主診醫生在第一線醫療環境中進行。
戒煙輔導	輔導協助戒煙。對於吸煙的受益人，聯邦醫療保險將賠付 12 個月之內的 8 次面對面輔導。
疫苗接種/預防注射	<u>流感</u> ：每個流感季節可注射一次。 <u>肺炎</u> ：通常一生中只需要注射一次。第二針在注射第一針後 12 個月承保。 <u>乙肝</u> ：若是處於中高危險狀態可獲賠付。

MEDICARE AS SECONDARY PAYER WHO PAYS FIRST?

When a person has Medicare and other health insurance coverage, it is necessary to understand which insurance is primary, and which is secondary. The primary insurance is the one that will consider the claim first and the secondary insurance will consider any balance after the claim has been paid or denied by the primary insurance.

Individuals who are new to Medicare will receive a letter in the mail asking that they complete the Initial Enrollment Questionnaire (IEQ). This questionnaire asks if you have group health plan coverage through your employer or a family member's employer. The IEQ can be completed online, at the beneficiary's MyMedicare.gov account, or over the phone by calling 1-855-798-2627.

If you have questions about who pays first, or if your coverage changes, call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627.

This chart shows who pays first in cases where someone has Medicare and insurance from a current employer:

YOU ARE...	YOUR EMPLOYER	MEDICARE WILL PAY...
65+ covered by employer plan	Less than 20 employees	First. Employer plan second.
65+ covered by employer plan	20 or more employees	Second. Employer plan first.
65+ covered by spouse's employer plan	Less than 20 employees	First. Employer plan second.
65+ covered by spouse's employer plan	20 or more employees	Second. Employer plan first.
Disabled under 65 covered by employer plan	Less than 100 employees	First. Employer plan second.
Disabled under 65 covered by employer plan	100 or more employees	Second. Employer plan first.
Disabled under 65 covered by other family member plan	Less than 100 employees	First. Employer plan second.
Disabled under 65 covered by other family member plan	100 or more employees	Second. Employer plan first.
Any age with End Stage Renal Disease (ESRD) covered by employer plan of self or other family member	Any number of employees	Second for the first 30 months of Medicare enrollment. After 30 months, Medicare is primary.

Liability Insurance and Medicare: In situations of an accident or injury, the expenses of medical care may be covered by other types of insurance such as no-fault or automobile insurance, homeowners or malpractice policies. Since many liability claims take a long time to be settled, Medicare can make conditional payments for these cases to avoid delays in reimbursement to providers and liability to beneficiaries. Medicare will pay the claim and later seek to recover the conditional payments from the settlement amount.

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險為副保險 誰先承保付費？

當個人同時擁有聯邦醫療保險和其他健康保險時，必須瞭解何者是主保險、何者是副保險。主保險是首先考量理賠的保險，副保險則是在主保險的理賠獲得賠付或遭拒之後再對任何餘額進行考量。

新參與聯邦醫療保險的人士將收到一封寄來的信函，要求填寫首次註冊問卷 (IEQ)。該問卷調查您是否透過您的雇主或家人的雇主參與團體健康保險計畫。可使用受益人的 MyMedicare.gov 賬戶在線填寫 IEQ，或致電 1-855-798-2627 透過電話完成問卷。

如對誰先承保付費有疑問，或您的保險發生變更，請致電福利協調及康復中心 (BCRC)：1-855-798-2627。

本表顯示在擁有聯邦醫療保險和目前雇主提供保險的情況下，何者先賠付：

您是...	您的雇主有...	聯邦醫療保險賠付將是...
65 歲以上，有雇主保險計畫	員工人數不及 20 人	第一順位。雇主保險計畫為第二順位。
65 歲以上，有雇主保險計畫	員工人數在 20 人或以上	第二順位。雇主保險計畫為第一順位。
65 歲以上，配偶有雇主保險計畫	員工人數不及 20 人	第一順位。雇主保險計畫為第二順位。
65 歲以上，配偶有雇主保險計畫	員工人數在 20 人或以上	第二順位。雇主保險計畫為第一順位。
65 歲以下的殘障人士，有雇主保險計畫	員工人數不及 100 人	第一順位。雇主保險計畫為第二順位。
65 歲以下的殘障人士，有雇主保險計畫	員工人數在 100 人或以上	第二順位。雇主保險計畫為第一順位。
65 歲以下的殘障人士，有其他家庭成員的保險計畫	員工人數不及 100 人	第一順位。雇主保險計畫為第二順位。
65 歲以下的殘障人士，有其他家庭成員的保險計畫	員工人數在 100 人或以上	第二順位。雇主保險計畫為第一順位。
患有末期腎臟疾病 (ESRD) 者，年齡不限，自己有雇主保險計畫，或是有其他家庭成員的保險計畫	員工人數不限	登記加入聯邦醫療保險後的首 30 個月為第二順位。30 個月之後，則以聯邦醫療保險為主保險。

責任保險和聯邦醫療保險：在意外事故或受傷的情況下，醫療支出可能會由其他型態的保險支付，例如：無過失保險或汽車保險、住宅綜合險或執業過失險。由於許多理賠申請都需要很長時間才能解決，聯邦醫療保險可以進行有條件賠付，以避免對醫療業者的償款延宕並成為受益人的欠款負擔。聯邦醫療保險將先進行理賠，日後再尋求從結算金額中收回有條件的賠付。

請致電 311 洽詢 HIICAP

Working After Age 65-Employer Group Health Plans (EGHP) and Medicare: When a Medicare beneficiary over age 65 continues to work, their employer or their spouse's employer must provide the same coverage for all employees and families, regardless of age. If there are 20 or more employees in the company where a Medicare beneficiary or spouse work, the EGHP is primary and Medicare is secondary. If there are fewer than 20 employees, then Medicare is primary and the EGHP is secondary. Medicare Part B is always open to those who are working who have employer coverage. Look on the Medicare website at www.medicare.gov or call 1-800-MEDICARE for more information. Some employers require that those who are eligible for Medicare enroll in Medicare Parts A and/or B; it is advised to contact the employer about this issue.

When the employee chooses to retire, he needs to consider enrolling in Medicare Part B, since Medicare Part B will be his primary insurance upon retirement. There is a monthly premium for Part B. Enrollment in Medicare Part B should be done within 8 months of the end of active employment, not at the end of health care coverage, in order to avoid a possible gap in coverage and a late enrollment penalty.

Retiree Health Coverage: In cases where someone has both Medicare and retiree health insurance, Medicare is primary and the retiree coverage is secondary.

Disability and Medicare: If a person becomes disabled and is unable to work, an EGHP generally covers the costs. If the company employs 100 or more individuals, the EGHP is primary and Medicare is secondary. If there are fewer than 100 employees, Medicare is primary and the EGHP is secondary. Disability, as determined by Social Security, will entitle an individual to Medicare coverage after the 24th month of disability payments without regard to age.

End Stage Renal Disease (ESRD): Some individuals are eligible for Medicare Part B coverage because they have End Stage Renal Disease and are either receiving maintenance dialysis treatments or have had a kidney transplant. If there is an employer group health plan, it is primary during the first 30 months of Medicare eligibility. After 30 months, Medicare is primary.

Worker's Compensation and Medicare: Worker's Compensation is usually primary in the event of a job-related injury and covers only health care expenses related to the injury. Pre-existing conditions can be paid by Medicare if Worker's Compensation does not cover these conditions.

Federal Black Lung Program and Medicare: The Federal Black Lung Program provides services related to lung disease and other conditions caused by coal mining. Medicare will also cover services unrelated to black lung for these same individuals.

65 歲以後繼續工作 — 雇主團體健康保險 (EGHP) 和聯邦醫療保險: 聯邦醫療保險受益人若超過 65 歲仍繼續工作，他們的雇主或配偶的雇主必須為所有的員工及其家人提供相同的保障，無論年齡為何。若聯邦醫療保險受益人或配偶所工作的公司擁有 20 名以上員工，則 EGHP 為主保險，而聯邦醫療保險為副保險。若公司員工人數不及 20 人，則以聯邦醫療保險為主保險，而 EGHP 為副保險。聯邦醫療保險 B 部分對有工作並有雇主保險的人士始終開放。請瀏覽聯邦醫療保險網站 www.medicare.gov 或致電 1-800-MEDICARE 以瞭解詳情。有些雇主要求符合聯邦醫療保險資格者須加入聯邦醫療保險 A 部分和/或 B 部分；建議洽詢雇主以瞭解此點。

當員工選擇退休時，他必須考慮加入聯邦醫療保險 B 部分，因為一旦退休，聯邦醫療保險 B 部分將成為其主保險。B 部分須繳交月保費。在受雇終止後的 8 個月內必須登記加入聯邦醫療保險 B 部分，而非在醫療保險終止後再加入，以免保險可能無法銜接及面臨延遲加入罰金。

退休人士健康保險: 若是同時擁有聯邦醫療保險和退休人士健康保險，聯邦醫療保險為主保險，退休人士保險為副保險。

殘障和聯邦醫療保險: 若是淪為殘障而無法工作，EGHP 通常會負擔費用。若公司員工人數在 100 人以上，EGHP 為主保險，聯邦醫療保險為副保險。若員工人數不及 100 人，聯邦醫療保險為主保險，EGHP 則為副保險。若符合社會安全保險界定為殘障人士，則在連續領取 24 個月的殘障津貼之後即可獲得聯邦醫療保險的保障，不限年齡。

末期腎臟疾病 (ESRD): 有些人符合聯邦醫療保險 B 部分保障的資格是因為患有末期腎臟疾病，並且接受長期洗腎或曾進行腎臟移植。若有雇主團體健康保險計畫，在符合聯邦醫療保險資格的首 30 個月以雇主保險為主保險。30 個月之後，則以聯邦醫療保險為主保險。

勞工賠償和聯邦醫療保險: 在與工作有關的受傷事件中，勞工賠償通常是主保險，並且只賠付與受傷有關的醫療護理支出。若勞工賠償不賠付先前存在的病情，則可由聯邦醫療保險支付。

聯邦塵肺症方案和聯邦醫療保險: 聯邦塵肺症方案提供與肺病及其他因煤礦工作導致之病症相關的服務。聯邦醫療保險也將對當事人與塵肺症無關的醫療服務提供賠付。

MEDICARE SUPPLEMENT INSURANCE (Medigap)

What Is A Medigap Policy?

Medicare Supplement Insurance (Medigap) is specifically designed to fill the gaps in Medicare coverage. Regulated by federal and state laws, the policies can only be purchased from private companies. You must have Medicare Parts A and B to purchase a Medigap policy.

Why Do I Need A Medigap Policy?

A Medigap policy offers reimbursement for out-of-pocket health service costs not covered by Medicare, which are the beneficiary's share of costs. For example, a Medigap policy might cover the Part A deductible, the Part B outpatient co-insurance of 20% of allowed charges, and other costs. **Note that some plans only cover a percentage of these costs, while other plans cover them in full.** Medicare Advantage plan enrollees should not enroll in a Medigap plan, as this would duplicate coverage they have through their Medicare Advantage plan.

What Medigap Policies Are Available?

There are ten standard Medigap policies available in the United States, designated "A" through "N." Each of the policies covers the basic benefit package (which cannot be changed by adding or subtracting the provisions), plus a combination of additional benefits. Older Medigap policies from before the 1992 standardization are still in effect, but cannot be offered to new enrollees. Individuals with an older policy can switch to a new, standard policy, but would not be allowed to go back to the old policy. Some of the older policies may provide better coverage, especially for extended skilled nursing care. Effective June 1, 2010, plans E, H, I and J are no longer offered to new enrollees. Individuals with Medigap plans E, H, I and J can maintain their existing coverage, but may wish to compare benefits with the premium cost to determine whether their plan remains cost effective.

When can I Enroll in a Medigap Policy?

In New York State, you can purchase a Medigap policy at any time when you are enrolled in Medicare. You are guaranteed the opportunity to purchase a policy even if you are under age 65 and have Medicare due to disability.

When Can I Switch Medigap Policies?

In New York State, you can switch the company from which you get the Medigap policy, as well as the type of Medigap policy, at any time. Some companies require you to remain in a certain plan for a period of time before switching to a different plan that they offer. However, you can still get the desired plan from a different company that offers that plan.

How Do I Choose A Medigap Policy?

Since Medigap plans are standardized, you first need to decide the level of coverage you need. Once you establish which plan's set of benefits is right for you, you can compare the premium, service and reputation of the insurance companies. Most Medigap insurers have linked their computers with the computers at Medicare, so that your claims can be processed without additional paperwork ("electronic crossover"). In addition, companies can bill the premium monthly, quarterly or annually; your preference may be for a particular payment schedule.

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險補充保險 (Medigap)

醫療補充保險是什麼？

聯邦醫療保險補充保險 (Medigap) 是特別為彌補聯邦醫療保險賠付的缺口而設計。受到聯邦及各州法令管轄，該類保險只能向私營公司購買。您必須有聯邦醫療保險的 A 部分和 B 部分，才能購買醫療補充保險。

為什麼需要醫療補充保險？

醫療補充保險為聯邦醫療保險不承保而已支付的醫療服務費用 (受益人的分攤費用) 提供償款。例如，醫療補充保險可賠付 A 部分的自付額、B 部分核准費用 20% 的門診共保額，以及其他費用。請注意，有些保險計畫只依百分比賠付這些費用，其他計畫則賠付全額。已加入聯邦醫療保險優勢計畫的人士不應再參加醫療補充保險計畫，因為這與他們在聯邦醫療保險優勢計畫中所獲得的保障是重複的。

醫療補充保險有那些？

在美國有 10 種標準型醫療補充保險，以英文字母 A 至 N 來標示。每一項保險計畫都含有基本保險賠付配套 (不得增減條款以更改內容)，再加上附加保險賠付組合。1992 年標準化之前的舊式醫療補充保險保單仍然有效，但不能提供予新加入者。持有舊保單者可以轉換新的標準型保單，但不得再恢復持有舊保單。有些舊保單所提供的承保範圍可能較佳，尤其是在延長專業護理方面。自 2010 年 6 月 1 日起，E、H、I 及 J 計畫不再提供予新加入者。持有 E、H、I 及 J 計畫者可以維持他們的現有承保，但可能應該比較一下賠付與保費成本，以判斷他們的計畫是否仍具有成本效益。

何時可以登記加入醫療補充保險？

在紐約州，登記加入聯邦醫療保險之後，隨時都可以購買醫療補充保險。即使年齡在 65 歲以下，並且是因為殘障而取得聯邦醫療保險，也保證有機會可以購買醫療補充保險。

何時可以轉換醫療補充保險？

在紐約州，您隨時可以轉換提供醫療補充保險的公司，以及醫療補充保險的類型。有些公司會要求您必須在某項計畫內維持一段時間，然後才可以轉換至該公司所提供的不同計畫。然而，您仍然可以從提供該計畫的另一家公司取得想要的計畫。

如何選擇醫療補充保險？

由於醫療補充保險計畫都是標準化形式，首先必須決定您所需要的保障級別。一旦確定何種賠付組合符合您的需要，就可以比較各保險公司的保費、服務和聲譽。大多數醫療補充保險業者都將其電腦與聯邦醫療保險的電腦連線，因此您的理賠申請無需另外進行紙上作業即可處理 (「電子跨界」)。此外，保險公司可用月繳、季繳或年繳方式收取保費；您可自行選擇以上付款時間段。

請致電 311 洽詢 HIICAP

How Am I Protected?

All standard Medigap policies sold today are guaranteed renewable. The insurance company cannot refuse to renew the policy unless you do not pay the premiums or you made misrepresentations on the application. Federal law prohibits an insurance company or salesperson from selling you a second Medigap policy that duplicates coverage of one you already have, thus protecting you from pressure to buy more coverage than you need. You can switch Medigap policies whenever you need a different level of coverage. When your health needs are greater, you can arrange to purchase a Plan F, for example, if you find plan B is too limited. The new Medigap policy would replace the previous one. DO NOT CANCEL THE OLD POLICY UNTIL THE NEW ONE IS IN EFFECT.

How Are Premiums Determined?

In New York State, you are protected by "community rating." The premium set by an insurance company for one of its standard Medigap policies is required to be the same without regard to age, gender or health condition. That means that the premium for Plan C from one insurance company will be the same for a woman, aged 72 in poor health as it will be for a man, aged 81, in good health. A chart of the ten standard plans follows the description of the plans. The insurance companies and their premiums for NYC Medicare beneficiaries can be found on page 21.

When Will My Coverage Start if I Have a Pre-Existing Health Condition?

The maximum period that a Medigap policy's coverage can be denied for a pre-existing health condition is the first six months of the new policy and only for those claims that are directly related to that health problem. A pre-existing condition is a condition for which medical advice was given, or treatment was recommended by, or received from, a physician within six months before the effective date of coverage. You may qualify for **immediate** coverage for a pre-existing health condition (1) if you buy a policy during the open enrollment period after turning 65 or (2) if you were covered under a previous health plan for at least six months without an interruption of more than 63 days. If your previous health plan coverage was less than six months, your new Medigap policy must credit you for the number of months you had coverage. Some insurers have shorter or no waiting periods for pre-existing conditions. A chart with the waiting periods for pre-existing conditions can be found online at http://dfs.ny.gov/consumer/caremain.htm#sub_gen.

What Paperwork Will I Receive From My Medigap Insurer?

A Medigap insurance company is required to send you an Explanation of Benefits to document that it paid its portion of your claims for your health benefits. Combined with the Medicare Summary Notice (MSN) which you receive from Medicare, you will have the total information about how your health care claim was processed.

How Can I Get Help In Choosing A Medigap Policy?

Trained HIICAP counselors have current information on Medigap policies. They will not make the choice for you, but they will give you the specific information you need to make your decision.

CALL 311 AND ASK FOR HIICAP

我如何受到保護？

現在售出的所有標準型醫療補充保險都保證可以續約。保險公司不得拒絕續約，除非您未繳保費或在申請時資料不實。聯邦法令禁止保險公司或銷售人員賣給您的第二份醫療補充保險保單是與您已有的保障重複，從而保護您免於購買過多不必要保險的壓力。在您需要不同程度的保障時，隨時可以轉換醫療補充保險。例如，當您的醫療需求增加時，如果發現 B 計畫的保障太有限，可以安排購買 F 計畫。新的醫療補充保險將會取代前者。在新保單生效前切勿取消舊保單。

保費是如何決定的？

在紐約州，您受到「社區費率」的保障。保險公司為其一項標準型醫療補充保險所設定的保費必須相同，不得因年齡、性別或健康狀況而有差異。這表示以一家保險公司 C 計畫的保費而言，72 歲、健康狀況不佳的女性和 81 歲、健康狀況良好的男性將是一樣的。在保險計畫的說明之後附有 10 種標準型計畫的列表。保險公司及其為紐約市聯邦醫療保險受益人所制訂的保費，請見第 20 頁。

若有投保前已經存在的病況，保險將於何時開始？

醫療補充保險的保障可因投保前已經存在的病況而遭到拒絕，最長期限為新保單生效後的 6 個月之內，並僅限於與該項醫療問題直接相關的理賠要求。投保前已經存在的病況是指在保險生效前的 6 個月內，醫生已針對該病況提供了醫療建議、治療建議，或已接受醫生治療。對於投保前已經存在的病況，您可能有資格享有立即保障，條件是：(1) 若您在年滿 65 歲後的開放參加期內購買保險，或 (2) 若您之前投保的醫療保險為期至少 6 個月，且未中斷超過 63 天。若您之前投保醫療保險的時間不到 6 個月，新的醫療補充保險必須按您有保險的月數提供保障。有些保險公司對於投保前已經存在的病況所設定的等候期較短或沒有等候期。投保前已存在病況等候期的圖表可參見網上 http://dfs.ny.gov/consumer/caremain.htm#sub_gen。

我會從醫療補充保險業公司處收到什麼文件？

醫療補充保險公司必須寄給您賠付說明，以文件證明其支付了您所提出的醫療理賠要求中由承保公司負責的部分。加上您從聯邦醫療保險所收到的聯邦醫療保險摘要通知 (MSN)，您將擁有醫療理賠如何處理的全部資訊。

如何取得協助以選擇醫療補充保險？

受過專業訓練的 HIICAP 輔導員擁有醫療補充保險的最新資訊。他們不會幫您做決定，但是會提供您做決定時所需要的特定資訊。

請致電 311 洽詢 HIICAP

How Does Medicare Part D Interact with Medigap Policies?

No new Medigap policies offer drug coverage. There is no interaction between newer Medigap policies and Part D.

STANDARD MEDIGAP PLANS

Below are the ten standard plans, Plans A–N, and the benefits provided by each:

PLAN A (the basic policy) consists of these **basic benefits**:

- Coverage for the Part A copayment amount (\$322 per day in 2016) for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for the Part A copayment amount (\$644 per day in 2016) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for Medicare Part A hospice care cost-sharing.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount), after the annual deductible is met (\$166 in 2016).

PLAN B includes the **basic benefit, plus**

- Coverage for the Medicare Part A inpatient hospital deductible (\$1,288 per benefit period in 2016).

PLAN C includes the **basic benefit, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care copayment amount (\$161 per day for days 21 through 100 per benefit period in 2016).
- Coverage of the Medicare Part B deductible (\$166 per calendar year in 2016).
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible and \$50,000 lifetime maximum benefit.

PLAN D includes the **basic benefit, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily copayment amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible and \$50,000 lifetime maximum benefit.

聯邦醫療保險 D 部分與醫療補充保險如何交相運作？

新的醫療補充保險都不提供藥品費賠付。較新的醫療補充保險與 D 部分之間不相關。

標準型醫療補充保險計畫

以下為 10 種標準型計畫，計畫 A 至 N，以及每項計畫所提供的賠付：

A 計畫 (基本保單) 含有下列**基本賠付**：

- 在每一段聯邦醫療保險權益期內第 61 至 90 天的住院治療，賠付 A 部分共付額 (2016 年為每天 \$322)。
- 對於聯邦醫療保險不可續延的 60 天住院終身儲備期，每一天都提供 A 部分共保額賠付 (2016 年為每天 \$644)。
- 在聯邦醫療保險的住院賠付全部用罄之後，對於聯邦醫療保險 A 部分的合格住院支出提供 100% 賠付。在保單持有人的一生中，追加住院治療的賠付上限為 365 天。
- 對聯邦醫療保險 A 部分安寧療護的費用分攤提供賠付。
- 依聯邦醫療保險 A 部分和 B 部分，每一日曆年為最初 3 品脫血液或等量的紅血球濃厚液的合理費用提供賠付，除非是遵從聯邦規定而更換。
- 在達到年度自付額 (2016 年為 \$166) 之後，為 B 部分服務的共保額提供賠付 (一般為核准金額之 20%)。

B 計畫包括**基本賠付**，另加

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付 (2016 年每一段權益期為 \$1,288)。

C 計畫包括**基本賠付**，另加

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付。
- 對專業護理設施的共付額提供賠付 (2016 年每一段權益期的第 21 天至 100 天為每天 \$161)。
- 對聯邦醫療保險 B 部分自付額提供賠付 (2016 年為每日曆年 \$166)。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 \$250，而一生最高賠付上限為 \$50,000。

D 計畫包括**基本賠付**，另加

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付。
- 對專業護理設施的每日共付額提供賠付。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 \$250，而一生最高賠付上限為 \$50,000。

PLAN F¹ includes:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges².
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible and \$50,000 lifetime maximum benefit.

PLAN G includes the **basic benefit, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily copayment amount.
- Coverage for 100% of Medicare Part B excess charges².
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible and \$50,000 lifetime maximum benefit.

Effective June 2010, Medigap policies E, H, I and J are no longer sold to new policyholders. However, individuals who had an E, H, I or J policy prior to June 2010 can keep their policy.

PLAN K³ includes the **basic benefit, plus**

- Coverage for 50% of the Medicare Part A inpatient hospital deductible.
- Coverage for 50% of Part B coinsurance after you meet the yearly deductible for Medicare Part B, but 100% coinsurance for Part B preventive services.
- Coverage for 100% of the Part A copayment amount for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A copayment amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of
- 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for 50% hospice cost-sharing.
- Coverage for 50% of Medicare-eligible expenses for the first 3 pints of blood.
- Coverage for 50% of the skilled nursing facility care daily copayment amount.
- Annual out of pocket limit of \$4,960 in 2016.

¹ Plan F also has a "high deductible option." If you choose the "high deductible option," you will first have to pay a \$2,180 deductible in 2016 before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums.

² Plan pays the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

³ The basic benefits for plans K, L, M and N include similar services as plans A-G, but the cost-sharing for the basic benefits is at different levels. The annual out-of-pocket limit can increase each year for inflation.

F 計畫¹ 包括:

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付。
- 對專業護理設施的每日共保額提供賠付。
- 對聯邦醫療保險 B 部分自付額提供賠付。
- 對聯邦醫療保險 B 部分超額費用提供 100% 賠付²。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 \$250，而一生最高賠付上限為 \$50,000。

G 計畫包括**基本賠付**，另加

- 對聯邦醫療保險 A 部分住院治療自付額提供賠付。
- 對專業護理設施的每日共付額提供賠付。
- 對聯邦醫療保險 B 部分超額費用提供 100% 賠付²。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 \$250，而一生最高賠付上限為 \$50,000。

自 2010 年 6 月起，醫療補充保險的 E、H、I 和 J 計畫不再售予新的保單持有人。不過，在 2010 年 6 月之前即擁有 E、H、I 或 J 計畫保單者仍可保有他們的保單。

K 計畫³ 包括**基本賠付**，另加

- 對聯邦醫療保險 A 部分住院治療自付額提供 50% 賠付。
- 對 B 部分共保額提供 50% 賠付，唯須先支付聯邦醫療保險 B 部分的年度自付額；不過，B 部分預防性醫療服務的共保額可獲得 100% 賠付。
- 對每一段聯邦醫療保險權益期內住院治療第 61 天至 90 天的 A 部分共付額提供 100% 賠付。
- 對於聯邦醫療保險不可續延的 60 天住院終身儲備期，為耗用之每一天的 A 部分共付額提供 100% 賠付。
- 在聯邦醫療保險的住院賠付全部用罄之後，對於聯邦醫療保險 A 部分的合格住院支出提供 100% 賠付。在保單持有人的一生中，
- 追加住院治療的賠付上限為 365 天。
- 對安寧療護的費用分攤提供 50% 賠付。
- 對符合聯邦醫療保險條件的最初 3 品脫血液費用提供 50% 賠付。
- 對專業護理設施的每日共付額提供 50% 賠付。
- 2016 年的年度自付費用限額為 \$4,960。

¹ F 計畫亦有「高自付額選項」。若選擇「高自付額選項」，在 2016 年您必須先支付 \$2,180 自付額之後，該保險計畫才會開始賠付。此一金額可能每年提高。高自付額保單的保費較低。

² 保險計畫會支付聯邦醫療保險核准之 B 部分服務金額與實際費用（最高可達聯邦醫療保險或州法所設定的收費上限金額）之間的差額。

³ K、L、M 和 N 計畫內的基本賠付與 A 至 G 計畫包括的醫療服務相似，但對基本賠付的分攤費用則屬不同級別。年度自付費用限額可因通貨膨脹而每年調整。

PLAN L³ includes the **basic benefit, plus**

- Coverage for 75% of Medicare Part A inpatient hospital deductible.
- Coverage for 75% of Part B coinsurance after you meet the yearly deductible for Medicare Part B, but 100% coinsurance for Part B preventive services.
- Coverage for 100% of the Part A copayment amount for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A copayment amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for 75% hospice cost-sharing.
- Coverage for 75% of Medicare-eligible expenses for the first 3 pints of blood.
- Coverage for 75% of the skilled nursing facility care daily coinsurance amount.
- Annual out of pocket limit of \$2,480 in 2016.

Plan M³ includes the **basic benefit, plus**

- Coverage for 50% of the Medicare Part A inpatient hospital deductible.
- Coverage for 100% of the skilled nursing facility daily copayment amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible and \$50,000 lifetime maximum benefit.

Plan N³ includes the **basic benefit, plus**

- Coverage for 100% of the Medicare Part A inpatient hospital deductible.
- Coverage for 100% of the Medicare Part B co-insurance amount, except for up to \$20 co-payment for office visits and up to \$50 co-payment for emergency room visits.
- Coverage for 100% of the skilled nursing facility daily copayment amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible and \$50,000 lifetime maximum benefit.

Medicare SELECT: In addition to the standard Medigap policies A-N, Medicare SELECT is a type of Medigap policy that can cost less than standard Medigap plans. However, you can only go to certain hospitals and in some cases, certain doctors for your care. Visit <http://www.dfs.ny.gov/consumer/caremain.htm#insurer> for information on Medicare SELECT plans available in New York State.

Always consider inquiring about a particular membership or group insurance rate from a current or previous employer that might be less expensive than purchasing an individual plan on your own.

See pages 19 and 20 for more information on Medigap policies.

L 計畫³包括基本賠付，另加

- 對聯邦醫療保險 A 部分住院治療自付額提供 75% 賠付。
- 對 B 部分共保額提供 75% 賠付，唯須先支付聯邦醫療保險 B 部分的年度自付額；不過，B 部分預防性醫療服務的共保額可獲得 100% 賠付。
- 對每一段聯邦醫療保險權益期內住院治療第 61 天至 90 天的 A 部分共付額提供 100% 賠付。
- 對於聯邦醫療保險不可續延的 60 天住院終身儲備期，為耗用之每一天的 A 部分共付額提供 100% 賠付。
- 在聯邦醫療保險的住院賠付全部用罄之後，對於聯邦醫療保險 A 部分的合格住院支出提供 100% 賠付。在保單持有人的一生中，追加住院治療的賠付上限為 365 天。
- 對安寧療護的費用分攤提供 75% 賠付。
- 對符合聯邦醫療保險條件的最初 3 品脫血液費用提供 75% 賠付。
- 對專業護理設施的每日共保額提供 75% 賠付。
- 2016 年的年度自付費用限額為 \$2,480。

M 計畫³包括基本賠付，另加

- 對聯邦醫療保險 A 部分住院治療自付額提供 50% 賠付。
- 對專業護理設施的每日共付額提供 100% 賠付。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 \$250，而一生最高賠付上限為 \$50,000。

N 計畫³包括基本賠付，另加

- 對聯邦醫療保險 A 部分住院治療自付額提供 100% 賠付。
- 對聯邦醫療保險 B 部分共保額提供 100% 賠付，唯對於至診所就診的共付額最高賠付上限為 \$20，至急診室就診的共付額最高賠付上限為 \$50。
- 對專業護理設施的每日共付額提供 100% 賠付。
- 對在外國接受的必要緊急治療提供 80% 賠付，唯須先扣除自付額 \$250，而一生最高賠付上限為 \$50,000。

聯邦醫療保險精選計畫 (SELECT)：除了標準型醫療補充保險 A 至 N 計畫之外，聯邦醫療保險精選計畫是較標準型計畫更為實惠的醫療補充保險。不過，您只能前往某些醫院，而且在某些情況下，您只能選擇某些醫生為您治療。請造訪網站 <http://www.dfs.ny.gov/consumer/caremain.htm#insurer> 以瞭解紐約州適用的聯邦醫療保險精選計畫相關資訊。

請務必查詢特殊會員資格，或現任或前任雇主所提供的團體保險費率，可能比自行購買個別保單更便宜。

請參考第 19 和 20 頁的列表以瞭解醫療補充保險的詳情。

³ The basic benefits for plans K, L, M and N include similar services as plans A-G, but the cost-sharing for the basic benefits is at different levels. The annual out-of-pocket limit can increase each year for inflation.

CALL 311 AND ASK FOR HIICAP

³ K、L、M 和 N 計畫內的基本賠付與 A 至 G 計畫包括的醫療服務相似，但對基本賠付的分攤費用則屬不同級別。年度自付費用限額可因通貨膨脹而每年調整。

請致電 311 洽詢 HIICAP

BENEFITS INCLUDED IN THE TEN STANDARD MEDICARE SUPPLEMENT PLANS

Basic Benefit: Included in all plans

- **Hospitalization:** Part A copayment, coverage for 365 additional days after Medicare benefits end, and coverage for 60 lifetime reserve days copayment.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses).
- **Blood:** First 3 pints of blood each year.
- **Hospice:** Part A cost sharing.

A	B	C	D	F*	G	K	L	M	N
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit**	Basic Benefit**	Basic Benefit	Basic Benefit**
		Skilled Nursing Coinsurance (50%)	Skilled Nursing Coinsurance (75%)	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance				
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible (50%)	Part A Deductible (75%)	Part A Deductible (50%)	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess	Part B Excess				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out of Pocket limit \$4,960	Out of Pocket limit \$2,480		

*Plan F is also offered with a high deductible option.

**These plans cover the basic benefit but with different cost-sharing requirements.

CALL 311 AND ASK FOR HIICAP

10 種標準型醫療補充保險計畫所包含的賠付

基本賠付：包含在所有的計畫內

- **住院治療：**A 部分共付額，在聯邦醫療保險賠付終止後另提供 365 天賠付，並對 60 天的終身儲備期共付額提供賠付。
- **醫療費用：**B 部分共保額 (一般為聯邦醫療保險核准費用之 20%)
- **血液：**每年的最初 3 品脫血液
- **安寧療護：**A 部分的分攤費用。

A	B	C	D	F*	G	K	L	M	N
基本賠付	基本賠付	基本賠付	基本賠付	基本賠付	基本賠付	基本賠付**	基本賠付**	基本賠付	基本賠付**
		專業護理共保額	專業護理共保額	專業護理共保額	專業護理共保額	專業護理共保額 (50%)	專業護理共保額 (75%)	專業護理共保額	專業護理共保額
	A 部分自付額	A 部分自付額	A 部分自付額	A 部分自付額	A 部分自付額	A 部分自付額 (50%)	A 部分自付額 (75%)	A 部分自付額 (50%)	A 部分自付額
		B 部分自付額		B 部分自付額					
				B 部分超額	B 部分超額				
		國外旅行緊急就醫	國外旅行緊急就醫	國外旅行緊急就醫	國外旅行緊急就醫			國外旅行緊急就醫	國外旅行緊急就醫
						自付費用上限 \$4,960	自付費用上限 \$2,480		

*F 計畫亦提供高自付額選項可供選擇。

**這些計畫均含基本賠付，但是費用分攤條件互異。

請致電 311 洽詢 HIICAP

MEDICARE SUPPLEMENT INSURANCE POLICIES

Prepared by the NYC Department for the Aging's Health Insurance Information Counseling Assistance Program (HIICAP) 1-212-602-4180. Please call the individual companies directly for their most current monthly rates as they are subject to change. Updated rate charts are available at the NY State Department of Insurance website at <http://www.dfs.ny.gov/consumer/medplan/medsup16.pdf>.

*First United American premiums differ by zip code. Go to: <https://myportal.dfs.ny.gov/web/guest-applications/medicare-monthly-premiums> for the rate in your zip code.

**Empire Blue Cross Blue Shield and Sterling Life no longer sell Medigap policies to new subscribers. They will continue to renew Medigap policies for current policyholders indefinitely, so long as they continue to pay their premiums.

PLAN	Aetna	American Progressive	Bankers Conesco	First United American*	GHI	Health Now New York	Humana	Mutual of Omaha	United Health (AARP)
	800-345-6022	800-332-3377	800-845-5512	800-331-2512	800-444-2333	888-989-9905	800-486-2620	800-228-9999	800-523-5800
A	\$318.21	\$231.09	\$335.51	\$201/221	\$169.45	\$263.59	\$268.44	\$233.99	\$156.50
B	\$362.44	\$322.51	\$399.06	\$276/303	\$226.14	\$328.18	\$303.02	\$359.10	\$222.50
C		\$400.57		\$333/366	\$273.50	\$393.64	\$363.68	\$432.48	\$260.00
D		\$398.11		\$328/361				\$378.61	
F	\$422.90	\$417.43	\$567.72	\$314/346	\$276.24	\$395.38	\$371.06	\$445.70	\$261.00
F+			\$83.99	\$62/68		\$167.35	\$115.86		
G		\$388.83	\$454.51	\$292/322				\$359.22	
K			\$116.48	\$123/136			\$175.07		\$82.75
L			\$238.11	\$173/191			\$249.91		\$152.25
M			\$329.71					\$368.79	
N		\$247.01	\$264.81	\$218/239			\$230.84		\$178.75

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險補充保險

由紐約市老人局的醫療保險資訊諮詢與協助計畫 (HIICAP) 製作，電話：1-212-602-4180。請直接致電各家公司以瞭解最新每月費率，費率變動恕不另行通知。最新費率表可在紐約州保險局網站查閱，網址為 <http://www.dfs.ny.gov/consumer/medplan/medsup16.pdf>。

*First United American 的保險費因郵政編碼而不同。請造訪：<https://myportal.dfs.ny.gov/web/guest-applications/medicare-monthly-premiums> 了解您的郵政編碼下的費用。

**Empire Blue Cross Blue Shield 和 Sterling Life 不再對新保戶銷售醫療補充保險。對於目前的保單持有人，只要繼續繳交保費，醫療補充保險將可無限期獲得續約。

計畫	Aetna	American Progressive	Bankers Conesco	First United American*	GHI	Health Now New York	Humana	Mutual of Omaha	United Health (AARP)
	800-345-6022	800-332-3377	800-845-5512	800-331-2512	800-444-2333	888-989-9905	800-486-2620	800-228-9999	800-523-5800
A	\$318.21	\$231.09	\$335.51	\$201/221	\$169.45	\$263.59	\$268.44	\$233.99	\$156.50
B	\$362.44	\$322.51	\$399.06	\$276/303	\$226.14	\$328.18	\$303.02	\$359.10	\$222.50
C		\$400.57		\$333/366	\$273.50	\$393.64	\$363.68	\$432.48	\$260.00
D		\$398.11		\$328/361				\$378.61	
F	\$422.90	\$417.43	\$567.72	\$314/346	\$276.24	\$395.38	\$371.06	\$445.70	\$261.00
F+			\$83.99	\$62/68		\$167.35	\$115.86		
G		\$388.83	\$454.51	\$292/322				\$359.22	
K			\$116.48	\$123/136			\$175.07		\$82.75
L			\$238.11	\$173/191			\$249.91		\$152.25
M			\$329.71					\$368.79	
N		\$247.01	\$264.81	\$218/239			\$230.84		\$178.75

請致電 311 洽詢 HIICAP

MEDICARE ADVANTAGE PLANS HMO, PPO, HMO-POS, SNP, MSA, PFFS

Medicare Advantage plans provide beneficiaries in New York City with alternatives to “original fee-for-service” Medicare. Medicare Advantage plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs, HMOs with Point-of-Service option (HMO-POS), Special Needs Plans (SNPs), Medicare Medical Savings Account (MSA) plans and Medicare Private Fee-For-Service (PFFS) plans. HMOs, PPOs, HMO-POS, SNP and PFFS plans involve a network of doctors, health centers, hospitals, skilled nursing facilities and other care providers for the enrolled member to use for their medical needs.

Medicare Advantage plans’ networks can be local, statewide, and even national. It is important to contact the plan to understand the scope of the provider network, especially if you travel and may require care other than emergency care outside your area of residence.

If you wish to have prescription drug coverage and belong to an HMO, PPO, HMO-POS or SNP, you must get the Part D drug coverage through your plan. If you belong to a PFFS plan that does not offer drug coverage, you can sign up for a separate Part D plan. Every Medicare Advantage plan must provide its members with all of the same medically-necessary services that “original” Medicare covers, and may include additional services, such as a prescription drug benefit, vision, dental and hearing services. All Medicare beneficiaries have the right to obtain the needed medical services, to get full information about treatment choices from their doctor and to appeal any denial of services or reimbursement made by a Medicare Advantage plan.

Each member of a Medicare Advantage plan must receive a Summary of Benefits as part of the enrollment process. Key information about additional premiums, routine procedures, access and notification requirements in an emergency, and co-payments for services must be outlined. A provider directory, a list of pharmacies in the plan and a formulary list of covered medications are also available from the plan.

Obtaining Services in Original Fee-for-Service Medicare, and Medicare Advantage

Original Fee-For-Service Medicare entitles the beneficiary to obtain all medically-needed services from any Medicare provider anywhere in the United States. Medicare sets the fees for those services and covers 80% of most costs. The beneficiary is responsible for the balance. Medicare supplement insurance, also known as Medigap (see page 14), can cover all or most of the senior’s share of the costs.

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險優勢計畫 HMO、PPO、HMO-POS、SNP、MSA、PFFS

聯邦醫療保險優勢計畫為紐約市的受益人提供「原始的付費服務」式聯邦醫療保險之外的選擇。聯邦醫療保險優勢計畫包含健康維護組織 (HMOs)、優選醫療機構計畫 (PPOs)、健康維護組織+療點服務 (HMO-POS)、特殊需求計畫 (SNPs)、聯邦醫療保險醫療儲蓄帳戶 (MSA) 計畫，以及聯邦醫療保險私營付費服務 (PFFS) 計畫。HMOs、PPOs、HMO-POS、SNP 和 PFFS 計畫是由醫生、保健中心、醫院、專業護理設施和其他醫護業者所構成的網絡，為網內會員提供醫護服務。

聯邦醫療保險優勢計畫的網絡可以是當地的、全州、甚至全國性的。實際聯絡該計畫以瞭解醫療業者網絡的區域範圍是很重要的，尤其是當您出外旅行而可能會在您居住以外的地區接受非緊急性的醫療照護時更是如此。

若您希望有處方藥保險，並且已加入一家 HMO、PPO、HMO-POS 或 SNP，您必須透過該計畫取得 D 部分藥品保險。若您所屬的 PFFS 計畫並不提供藥品保險，您可以加入單行的 D 部分計畫。每項聯邦醫療保險優勢計畫都必須提供與聯邦醫療保險原始計畫所承保之相同的必要醫療服務予其會員，並且可能含有更多服務，例如處方藥保險、眼科、牙科及聽力醫療服務。所有的聯邦醫療保險受益人都有權利取得所需的醫療服務、從醫生處獲得關於治療選擇的充分資訊，並且就聯邦醫療保險優勢計畫所駁回的任何服務或償款提出申訴。

聯邦醫療保險優勢計畫的每位會員在加入過程中都必須收到一份保險賠付摘要。其中必須明列關於追加保費、例行程序、緊急醫療服務的取得與通報要求，以及醫療服務的共付額等重要資訊。該計畫還會提供醫療業者名錄、參與計畫的藥房，以及保險賠付的藥物及費用計算清單。

在原始的付費服務式聯邦醫療保險以及聯邦醫療保險優勢計畫取得服務

原始的付費服務式聯邦醫療保險讓受益人可以從美國各地的任何聯邦醫療保險機構取得所有必要的醫療服務。聯邦醫療保險為這些服務設定收費，並且對大部分費用提供 80% 賠付。受益人有責任支付餘額。聯邦醫療保險補充保險亦即 Medigap (請見第 14 頁)，可為老年人所分攤的費用提供全額或大部分賠付。

請致電 311 洽詢 HIICAP

HMOs require the Medicare beneficiary to select a primary care physician (PCP) from the HMO's network of local doctors. Some HMOs require that the PCP provide a referral to specialists, though most do not require such referrals for in-network providers. Since the HMO receives a subsidy from the federal government, costs to the beneficiary may be lower than in fee-for-service Medicare. An HMO may offer additional benefits to those offered in fee-for-service Medicare, such as hearing aids, vision and dental care. Except for emergency care, there is no coverage for services obtained out-of-network; the beneficiary will be responsible for the full costs of such services.

PPOs provide a network of health care providers but do not restrict the enrollee from going out-of-network. The PPO sets its payment to in-network providers with a fixed co-pay from the enrollee; enrollees will pay more for services from out-of-network providers. (Out-of-network providers are subject to Medicare's limiting charge, which limits the amount they can charge a Medicare beneficiary for services.) Additional health benefits may be included in a PPO's plan, such as hearing aids, vision and dental care.

HMO with Point-Of-Service Option (HMO-POS) is very similar to a PPO plan. It provides greater flexibility than an HMO because members may use both in-network and out-of-network providers.

Special Needs Plans (SNP) are Medicare Advantage plans (HMOs or PPOs) that are available only to certain groups of people with Medicare. Examples of people who might be eligible to join a Medicare SNP include: people with both Medicare and Medicaid; people with certain chronic conditions; and people living in an institution, such as a nursing home. SNP coverage includes services covered by Medicare Parts A and B, as well as prescription drug coverage. They may also provide additional services that may be needed by the specific population to which they are geared. Eligible people with Medicare can join a SNP at any time.

A list of Medicare Advantage plans can be found in the U.S. Government's publication, Medicare and You Handbook. Details of the plans are available on www.medicare.gov or by calling 1-800-MEDICARE.

HMOs 要求聯邦醫療保險受益人從 HMO 的當地醫生網絡中選擇一位主理醫生 (PCP)。有些 HMOs 會要求由 PCP 轉介至專科醫生，不過若同為網內的醫療業者，大部分時候並不會要求這類轉介。由於 HMO 接受來自聯邦政府的補貼，向受益人所收取的費用可能低於付費服務式的聯邦醫療保險。HMO 可能提供比付費服務式聯邦醫療保險更多的保險賠付，例如助聽器、眼科和牙科護理。除急診治療外，對於在非網內所取得的醫療服務不提供賠付；受益人須自行負擔這類服務的全額費用。

PPOs 提供由醫療護理業者所組成的網絡，但是並不限制會員尋求網絡以外的醫療服務。PPO 有對網內的醫療業者賠付作設定，要求會員支付固定的共付額；對於非網內的醫療業者所提供的服務，會員則必須支付較高費用。（非網內業者須受到聯邦醫療保險收費限制的約束，限制業者能向聯邦醫療保險受益人收取醫療服務費用的金額。）PPO 計畫可能提供更多的健康保險賠付，例如：助聽器、眼科和牙科護理。

健康維護組織療點服務 (**HMO-POS**) 與 PPO 計畫非常類似。與 HMO 相較，HMO-POS 更有彈性，會員可以使用網內及非網內的醫療業者。

特殊需求計畫 (SNP) 是只提供予擁有聯邦醫療保險之特定族群的聯邦醫療保險優勢計畫 (HMOs 或 PPOs)。可能有資格加入聯邦醫療保險 SNP 的人士包括：同時擁有聯邦醫療保險和醫療補助的人士、患有某些慢性病症的人士；以及住在療養院之類機構的人士。SNP 的承保範圍包括由聯邦醫療保險 A 部分和 B 部分提供賠付的服務，以及處方藥保險。他們還可能提供更多針對某類特定人士所需而設置的服務。符合資格並擁有聯邦醫療保險的人士可以隨時加入 SNP。

聯邦醫療保險優勢計畫的詳細列表請見美國政府所出版的「聯邦醫療保險與您手冊」。計畫詳情請瀏覽網站 www.medicare.gov 或致電 1-800-MEDICARE。

Frequently Asked Questions about Medicare Advantage Plans

Who is Eligible to Enroll in a Medicare Advantage Plan?

In order to be eligible to enroll in a Medicare Advantage Plan, you must have both Medicare Part A and Part B; you must live in the plan's service area; and you cannot have permanent kidney failure. A Medicare Advantage plan cannot turn away an applicant because of health problems.

How is a Medicare Advantage Plan Paid?

When you choose to join a Medicare Advantage plan, the Centers for Medicare and Medicaid Services (CMS) pays the company a set amount each month to cover the medical services the average beneficiary is expected to need.

What Are My Out of Pocket Costs in a Medicare Advantage Plan?

Each Medicare Advantage plan sets its own premiums and cost sharing schedule. You may pay a monthly premium directly to the plan, which is in addition to the Part B premium. All cost sharing requirements must be clearly indicated to you on your benefit card or in your summary of benefits. Call the plan if you are not sure. **There may be co-pays, co-insurance and deductibles for health services.**

All Medicare Advantage Plans must have maximum out-of-pocket costs per year for all Part A and Part B covered services, which limits how much you will have to pay out-of-pocket in a given calendar year. In 2016, maximum out-of-pocket costs (MOOP) cannot exceed \$6,700 in-network for HMO plans and \$10,000 combined in-network and out-of-network for PPO plans.

How Does a Medicare HMO Work?

In an HMO, you select a Primary Care Physician (PCP) who is responsible for managing your medical care, admitting you to a hospital, ordering diagnostic tests and treatments, providing referrals to specialists, and writing your prescriptions. You have a choice of physician, provided he or she is available for patients who are new to Medicare. You must receive your health care from the HMO's providers; neither the HMO nor Medicare will pay for services from providers who are not part of the HMO's health care network, except in emergency situations.

How Does a Medicare PPO work?

A PPO is a network of doctors, hospitals and other providers. The enrollee can get services from within the network or go out of network. If you stay within the PPO's network, you will pay a co-payment (a set amount for certain services) that is probably less than the cost-sharing in "original" Medicare. If you go outside of the PPO's network with a referral to another provider or select another doctor or specialist, you will have to meet the plan's deductible and pay a higher fee for these services. The PPO will pay a set amount of the fee and you will pay the balance.

CALL 311 AND ASK FOR HIICAP

關於聯邦醫療保險優勢計畫的常見問題

誰有資格加入聯邦醫療保險優勢計畫？

欲符合參加聯邦醫療保險優勢計畫的資格，您必須同時擁有聯邦醫療保險 A 部分和 B 部分；必須居住在該計畫的服務地區；並且不能患有永久性腎衰竭。聯邦醫療保險優勢計畫不得因健康問題而拒絕申請人加入。

聯邦醫療保險優勢計畫如何賠付？

當您選擇加入聯邦醫療保險優勢計畫後，聯邦醫療保險和醫療補助服務中心 (CMS) 會每月付予該公司固定款項，以支應一般受益人可能需要的醫療服務。

在聯邦醫療保險優勢計畫中的自付費用為何？

每項聯邦醫療保險優勢計畫會設定其各自的保費和費用分攤方案。除了 B 部分保費之外，您可以用月保費的方式另外直接付予該計畫。所有的費用分攤規定都必須在您的保險卡上或保險賠付摘要中清楚說明。若有不確定之處，請致電該計畫。**保健服務可能會有共付額、共保額及自付額。**

對於 A 部分和 B 部分所承保的全部服務，所有的聯邦醫療保險優勢計畫都必須有每年自付費用的最高限，對您在每一日曆年所需負擔的自付費用設定限額。2016 年，HMO 計畫網絡內的自付費用最高限 (MOOP) 不得超過 \$6,700，而 PPO 計畫結合網內及非網內的最高限為 \$10,000。

聯邦醫療保險 HMO 是如何運作？

在 HMO，您選擇一位主理醫生 (PCP)，他負責掌理您的醫療護理、安排住院、決定診斷檢驗和治療、提供轉介至專科醫生，並且為您開立處方。您可以選擇醫生，前提是他或她願意接受新參加聯邦醫療保險的病人。您必須從 HMO 的醫療業者處接受醫療護理；若是不屬於 HMO 醫療護理網絡的業者，HMO 和聯邦醫療保險都不會對醫療服務提供賠付，除非是緊急狀況。

聯邦醫療保險 PPO 是如何運作？

PPO 是由醫生、醫院及其他醫療業者所構成的網絡。加入者可以從網內取得醫療服務，也可以向非網內的業者尋求服務。若是使用 PPO 網內的醫療服務，您所需支付的共付額 (為某些醫療服務所設定的固定費用) 可能低於聯邦醫療保險原始計畫的費用分攤部分。若是您轉介至 PPO 網絡外的另一家機構，或是選擇另一位醫生或專科醫生，則必須支付該計畫的自付額並為這些醫療服務支付較高的費用。PPO 將會賠付訂定的費用金額，餘額則由您來支付。

請致電 311 洽詢 HIICAP

How do Medicare Advantage Plans work with Medicare Part D (drug coverage)?

If you are in a Medicare Advantage Plan and want to have prescription drug coverage, you must get that coverage through your plan; you cannot join a separate Part D (stand-alone) plan.

What about Emergency Services?

Emergency medical care will be covered by the Medicare Advantage plan provided that you follow its requirements for notifications and approval. You may be required to pay the provider of services first, and then file a claim with the plan for reimbursement. If the plan determines the need for care does not meet its conditions, or if the notification was faulty, it may refuse to cover the costs.

How Can I Appeal a Decision By My Health Plan?

Decisions by your plan not to provide or pay for a service are handled by their claims department. If you are refused Medicare-covered services or denied payment for Medicare-covered supplies or treatments, you must be given a notice which will include your right to appeal.

How Do I Complain About Quality of Care?

If your complaint is related to the quality of health care you receive, you should follow your plan's grievance procedures. You can also present your case to the Medicare Quality Improvement Organization (QIO), Livanta, LLC, in New York State, whose doctors and other professionals review the care provided to Medicare patients. Livanta can be reached at 1-866-815-5440.

How Should I Decide Whether to Join a Medicare Advantage Plan?

Consideration should be given to the following three areas before joining a plan:

1) Your current doctors' participation in the plan; 2) finances and 3) geographical location.

1. **Your current doctors' participation in the plan:** Ask your doctors what plans they participate in and whether they are accepting new Medicare patients under that particular plan. Even if you already have an established relationship with that doctor, you need to be certain that they will accept you as a new patient under that particular plan.
2. **Finances:** Receiving care through a Medicare Advantage plan may cost you less than receiving care through original Medicare only. Medicare Advantage plans also may cover services which are not covered by original Medicare, such as routine vision and dental care, as well as hearing aids. It is important to research the fee structure in a Medicare Advantage plan before enrolling. Also, it is vital to make sure that you review this information each year.

聯邦醫療保險優勢計畫與聯邦醫療保險 D 部分 (藥品保險) 如何搭配運用？

若是參加聯邦醫療保險優勢計畫並希望擁有處方藥保險，就必須透過該計畫取得此項保險，不能加入單行的 D 部分計畫。

對急診服務的保障呢？

只要遵照通報規定並獲得核准，緊急醫療護理將能得到聯邦醫療保險優勢計畫的賠付。您可能需要先支付費用予醫療機構，然後再向該計畫申請理賠償款。若該計畫判定醫療護理需求不符合其條件，或是通報不實，則可能拒絕賠付該費用。

如何對健康保險計畫的判決提出申訴？

保險計畫不提供或拒絕賠付醫療服務的決定是由其理賠部門處理。若是聯邦醫療保險承保的醫療服務遭拒，或是聯邦醫療保險承保的用品或治療未獲賠付，您將會收到一份通知書，其中將包括您的申訴權利。

我該如何對醫護品質提出投訴？

若投訴是關於您所受到的醫護品質，應該遵照您的保險計畫的陳情程序。您也可向紐約州的聯邦醫療保險品質改善組織 (QIO) Livanta, LLC 提交您的個案，Livanta 的醫生及其他專業人士會審為聯邦醫療保險病人所提供的醫療護理。可致電 1-866-815-5440 聯絡 Livanta。

我該如何決定應否加入聯邦醫療保險優勢計畫？

在加入計畫之前，應該先考慮以下三方面：

1) 您目前的醫生是否參加該計畫；2) 財務狀況；和 3) 地理位置。

1. **您目前的醫生參加是否參加該計畫：**查詢您的醫生參加何種計畫，以及他們是否接受該特定計畫之下的聯邦醫療保險新病人。即便您原來是至該醫生處就診，仍必須確定他們將以該特定保險計畫的新病人身份向您提供服務。
2. **財務狀況：**經由聯邦醫療保險優勢計畫取得醫療護理的費用，可能低於僅透過聯邦醫療保險原始計畫取得醫療護理。聯邦醫療保險優勢計畫也可能承保聯邦醫療保險原始計畫所不承保的服務項目，例如：例行的眼科和牙科護理，以及助聽器。在加入之前仔細研究聯邦醫療保險優勢計畫的收費結構很重要。而且，每年務必查看這項資料也很重要。

3. **Geographical Location:** It is important to think about your travel plans when deciding whether an HMO plan is right for you. Because HMO plans have defined geographic areas that they serve, if you plan to be outside of the service area for any length of time, an HMO may not be right for you, since only emergency care is covered outside the plan's service area. The service areas of PPO and HMO-POS plans are less restrictive, but you should still be aware of the plan's service area.

What If I Want to Leave My Medicare Advantage Plan?

From October 15-December 7, you can change your Medicare Advantage (MA) plan choice or return to Original Medicare, with the change effective January 1. Between January 1 and February 14, people in Medicare Advantage plans have one additional opportunity to switch to Original Medicare, with the change effective the first of the following month, either February 1 or March 1. Individuals with Medicaid, a Medicare Savings Program or Extra Help can switch plans at any time, with the change effective the first of the following month.

If you want to leave one Medicare Advantage plan and enroll in another Medicare Advantage plan, contact the plan in which you wish to enroll (or 1-800-MEDICARE); you do not need to submit a written request.

Will I Need A Medicare Supplement Insurance Policy?

You will not need a Medicare Supplement Insurance policy ("Medigap") if you join a Medicare Advantage plan, as Medigap coverage would duplicate your benefits. If you decide to join a Medicare Advantage plan, and you already have a Medigap policy, you may want to retain it for at least 30 days, until you see if the Medicare Advantage plan is satisfactory. By New York State law, you will always be able to purchase a Medigap policy if you leave a Medicare Advantage plan and return to Original Medicare, but you may face a period of non-coverage for a current health condition. For more about Medigap, see page 14.

3. **地理位置：**在決定 HMO 計畫是否符合所需時，把旅行計畫列入考慮是很重要的。由於 HMO 計畫已界定提供服務的地理區域，若是打算在服務區域以外的地點停留，不論多久時間，HMO 可能都不適合您，因為在該計畫的服務區域以外，僅有緊急醫護可獲保險賠付。PPO 和 HMO-POS 計畫的服務區域限制較少，但您仍應留意該計畫的服務區域。

若想退出聯邦醫療保險優勢計畫怎麼辦？

從 10 月 15 日至 12 月 7 日，您可以更改聯邦醫療保險優勢 (MA) 計畫的選擇，或是回到聯邦醫療保險原始計畫，變更將從 1 月 1 日起生效。在 1 月 1 日至 2 月 14 日期間，參加聯邦醫療保險優勢計畫的人士將還有一次機會可以轉回聯邦醫療保險原始計畫，而自次月首日開始生效，亦即 2 月 1 日或 3 月 1 日。擁有聯邦補助、聯邦醫療保險免保費計畫或額外補助 (Extra Help) 者，則可以隨時轉換計畫，變更將於次月首日生效。

若是想要退出原來的聯邦醫療保險優勢計畫，然後加入另一項聯邦醫療保險優勢計畫，請聯絡您想參加的計畫 (或致電 1-800-MEDICARE)；您無須再遞送書面申請。

未來我還需要聯邦醫療保險補充保險嗎？

若是加入聯邦醫療保險優勢計畫，將不需要聯邦醫療保險補充保險 (Medigap)，因為醫療補充保險的承保範圍將與您的保險賠付重複。若是決定加入聯邦醫療保險優勢計畫，而您已經擁有聯邦醫療保險補充保險，則可以將其保留至少 30 天，直到您確定聯邦醫療保險優勢計畫令人滿意。根據紐約州法令，只要是退出聯邦醫療保險優勢計畫並回到聯邦醫療保險原始計畫，隨時都可以購買醫療補充保險，不過您可能會面臨一段時間對已有的病症沒有保險。關於醫療補充保險的詳情，請參見第 14 頁。

MEDICARE PART D – PRESCRIPTION DRUG COVERAGE

Medicare Part D is prescription drug coverage offered through private insurance companies to help cover the cost of prescription drugs.

Medicare prescription drug plans are available to all people with Medicare (Part A and/or Part B). A result of the Medicare Modernization Act of 2003, Medicare Part D adds prescription drug coverage benefits to Medicare's existing health benefits of Part A (hospitalization), Part B (outpatient services), and Medicare Advantage Plans. Part D is an optional and voluntary benefit; Medicare beneficiaries are not required to join a plan, although there may be a penalty for late enrollment.

Medicare Part D is unlike Parts A or B, as it is not standardized nationally but instead is offered through private-sector companies. Each private company designs its own plan for Medicare consumers. These plans have all entered into a contract with the federal government to provide Medicare Part D drug coverage through the Centers for Medicare and Medicaid Services (CMS) which regulates the plans and categories of covered drugs. When you sign up for a Part D plan, you are applying directly to a private company who negotiates the costs of your drugs with pharmacies, and has its own list of covered medications (formulary) and participating pharmacies, as well as its own procedures for getting a new drug covered or appealing to have a medication covered to meet your own special needs.

Medicare Part D is offered in one of two ways:

1. Medicare Advantage Prescription Drug Plans (MAPDs): these are managed care plans, such as HMOs, PPOs, HMO-POS, or SNPs, which offer comprehensive benefits packages that cover all of the following: hospital, doctors, specialists, pharmacy and prescriptions. If you are in a Medicare Advantage plan and want to have Part D coverage, you **must** get Part D coverage through your Medicare Advantage plan.
2. Stand Alone Prescription Drug Plans (PDPs): these plans **ONLY** cover prescription drugs.

Those electing to join a Part D plan will have to pay a monthly premium and pay a share of the cost of prescriptions. Drug plans vary in what prescription drugs are covered, how much you have to pay, and which pharmacies you can use. All drug plans have to provide at least a standard level of coverage, which Medicare sets. However, some plans offer enhanced benefits and may charge a higher monthly premium. When a beneficiary joins a drug plan, it is important to choose one that meets the individual's prescription drug needs.

Beneficiaries with higher incomes (above \$85,000 for an individual or \$170,000 for a couple) will pay a surcharge for Part D in addition to their plan premium. The surcharge ranges from \$12.70 to \$72.90 per month in 2016, and may be paid in the same way as the Part B premium, typically as a deduction from one's Social Security check (see page 62 for rate chart).

聯邦醫療保險 D 部分 — 處方藥保險

處方藥保險聯邦醫療保險 D 部分是透過私營保險公司提供的處方藥保險計畫，以協助支付處方藥費用。

聯邦醫療保險處方藥計畫適用於所有擁有聯邦醫療保險 (A 部分和/或 B 部分) 的人士。依據 2003 年聯邦醫療保險更新法，聯邦醫療保險 D 部分把處方藥保險賠付加至聯邦醫療保險 A 部分 (住院治療)、B 部分 (門診服務) 和聯邦醫療保險優勢計畫現有的健康保險賠付之中。D 部分是選擇性並且自動生效的保險賠付；聯邦醫療保險受益人無須強制加入計畫，不過延遲登記可能有處罰措施。

與 A 部分和 B 部分不同，聯邦醫療保險 D 部分並非全國統一標準，而是透過私營公司提供。每一家私營公司自行為聯邦醫療保險消費者設計計畫。這些計畫全都是與聯邦政府訂立契約的形式，透過聯邦醫療保險和醫療補助服務中心 (CMS) 提供聯邦醫療保險 D 部分藥品保險計畫，該中心負責監管保險計畫和承保藥品的類別。當您登記加入 D 部分計畫時，您是直接向一家私營公司申請，該公司會與藥房商議藥物成本，並有自訂的承保藥品 (處方藥) 及參與藥房列表，也有自己的作業程序以將新藥納入保險賠付，或是就藥物的承保提出申訴以滿足您的特殊需要。

聯邦醫療保險 D 部分以兩種方式提供：

1. 聯邦醫療保險優勢處方藥計畫 (MAPDs)：這些是管理式醫療計畫，例如：HMOs、PPOs、HMO-POS、或 SNPs，提供綜合性保險套裝計畫，承保範圍涵蓋以下各項：醫院、醫生、專科醫生、藥房和處方藥。若是已加入聯邦醫療保險優勢計畫，並且希望擁有 D 部分的承保內容，您必須透過聯邦醫療保險優勢計畫取得 D 部分保險。
2. 單行的處方藥保險計畫 (PDPs)：這些保險計畫只承保處方藥。

選擇加入 D 部分計畫者將須繳交月保費，並分攤部分處方藥費用。各家藥品保險計畫所承保的處方藥種類、自行付費額度及可以使用的藥房都有差異。所有的藥品計畫至少都必須提供由聯邦醫療保險所設定的基本承保範圍。然而，有些計畫會提供升級的保險賠付，並且可能收取較高的月保費。受益人參加藥品計畫時，選擇能夠符合個人處方藥需求的計畫很重要。

較高收入的受益人 (個人收入在 \$85,000 以上或夫妻收入在 \$170,000 以上) 除了繳交保險計畫的月保費之外，還要為 D 部分支付附加費。2016 年的附加費從每月 \$12.70 至 \$72.90 不等，並且得以用繳交 B 部分保費的相同方式支付，通常是從個人的社會安全福利金支票中扣除 (請見第 62 頁的費率表)。

Although Part D plans' benefit designs vary, they each include the following minimum levels of coverage in 2016:

- **Deductible** (up to \$360). Some plans have a lower deductible or no deductible.
- **Initial Coverage Level.** You pay 25% of drug costs up to \$3,310 in total drug costs. (Total drug costs include the amount that you pay for the drug plus the amount that the plan pays for the drug.)
- **Coverage Gap** (also known as the "donut hole"). After \$3,310 in total drug costs, you pay 45% of brand name drug costs and 58% of generic drug cost (plus a nominal pharmacy dispensing fee), until **you** have incurred \$4,850 in out-of-pocket costs. This includes the deductible (if any) plus any co-payments or coinsurance paid while reaching the Coverage Gap, the entire cost of brand name drugs purchased in the coverage gap, and the out-of-pocket costs for generic drugs purchased in the coverage gap.
- **Catastrophic Coverage** (after \$4,850 in out-of-pocket expenses). The beneficiary is responsible for the greater of five percent (5%) of drug costs or a \$2.95 co-payment for generic medications and \$7.40 for brand-name drugs.

The coverage gap is being gradually reduced beginning in 2011. In 2016, there is a 55% discount on brand name and a 42% discount on generic drugs purchased during the gap, and ending in 2020, with a flat 25% co-payment for both brand and generic drugs until catastrophic coverage is reached.

Enrollment in Medicare Part D

Enrollment in Medicare Prescription Drug Coverage involves choosing a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage prescription drug plan (MA-PD) offering drug coverage. Comparison information is available on www.medicare.gov or by calling 1-800-MEDICARE. You may also contact HIICAP for assistance.

Enrollment in Part D can occur during one's seven-month Initial Enrollment Period (IEP), (see pages 3-4). In addition, a beneficiary may join or change plans once each year between October 15 and December 7, during the Annual Coordinated Election Period (AEP). There are also limited exceptions where a beneficiary would be granted a Special Enrollment Period (SEP) to enroll in a Medicare Prescription Drug Plan or to switch plans outside of the AEP. These include the following situations:

- Dual eligible beneficiaries (those with **both** Medicare **and** full Medicaid), individuals in a Medicare Savings Program (QMB, SLMB, or QI), and those with Extra Help, can switch plans as often as every month, to be effective the first of the following month.
- EPIC members can change Part D plans once in a calendar year.
- People who are enrolled in a Part D plan with a 3-star or lower rating for 3 consecutive years can make a one-time change to a plan with 3 or more stars.
- Change in county of residence where one has new Part D plan choices. (This SEP also includes individuals returning to the USA after living abroad and those released from prison.)
- Individuals entering, residing in, or leaving a long-term care facility, including

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雖然 D 部分計畫的保險賠付設計互異，但在 2016 年每項計畫都包含下列最起碼的承保內容：

- **自付額** (最高至 \$360)。有些計畫的自付額較低或無需自付額。
- **初級承保範圍。** 自付藥品費用的 25%，藥品費用總額的最高限為 \$3,310。（藥品費用總額包括自付的藥品費用金額加上該計畫支付的藥品費用金額。）
- **保障缺口** (亦即「空窗部分」)。藥品費用總額達到 \$3,310 之後，您支付 45% 的原廠品牌藥費用和 58% 的非原廠等同藥費用 (額外象徵性地收取藥事服務費)，直到您自付費用達到 \$4,850 為止。此包括自付額 (如有自付額) 加上即將達到保障缺口時的任何共付額或共保額，在保障缺口期間購買原廠品牌藥的全部費用，以及在保障缺口期間購買非原廠等同藥的自付費用。
- **重大傷病賠付** (自付費用達 \$4,850 之後)。受益人須自行負擔以下金額較大者：5% 的藥品費用，或 \$2.95 的非原廠等同藥共付額及 \$7.40 的原廠品牌藥共付額。

從 2011 年開始，保障缺口逐步降低。2016 年，於保障缺口期間購買的原廠品牌藥有 55% 折扣，非原廠等同藥則有 42% 的折扣，至 2020 年結束時，原廠品牌藥和非原廠等同藥均為 25% 共付額，直至達到重大傷病賠付為止。

登記加入聯邦醫療保險 D 部分

登記加入聯邦醫療保險處方藥保險需要選擇提供藥品承保的聯邦醫療保險處方藥計畫 (PDP) 或聯邦醫療保險優勢處方藥計畫 (MA-PD)。可上網查閱兩者的比較：www.medicare.gov 或致電 1-800-MEDICARE。您也可以聯絡 HIICAP 尋求協助。

可在 7 個月的首次參加期 (IEP) 期間登記加入 D 部分，(請見第 3 頁至第 4 頁)。而且，在每年 10 月 15 日至 12 月 7 日的年度協調選擇期 (AEP) 期間，受益人可以加入或更改計畫一次。受益人也可能獲准在年度協調選擇期之外的特殊參加期 (SEP) 登記加入聯邦醫療保險處方藥計畫或轉換計畫，此為極有限的例外情況。其中包括以下情況：

- 具備雙重合格受益人身份 (同時擁有聯邦醫療保險和全額醫療補助)，參加聯邦醫療保險免保費計畫者 (QMB、SLMB 或 QI)，以及領取額外補助者，可以每個月轉換計畫，而於次月首日生效。
- EPIC 會員在日曆年內可更改 D 部分計畫一次。
- 連續 3 年登記參加 3 星級或低於該等級的 D 部分計畫者，可以一次性更改為 3 星級或更高等級的計畫。
- 所居住的郡縣改變而得以選擇新的 D 部分計畫。(此一特殊參加期也包括在國外居住後又回到美國者和出獄者。)

請致電 311 洽詢 HIICAP

skilled nursing facilities.

- Individuals disenrolling from employer/union-sponsored coverage, including COBRA, to enroll in a Part D plan.
- Prescription Drug Plan withdrawal from service area.

You can apply to join a Medicare Part D plan in several ways:

- Electronically on the internet, either through www.medicare.gov or the plan's website. HIICAP can assist you with online enrollment.
- Over the telephone by calling 1-800-MEDICARE or by calling the plan directly.
- In person, through a Part D plan's representative during a scheduled home visit or at a sales/marketing event.

Late Enrollment Penalty

Even if a person with Medicare does not currently use a lot of prescription drugs, he or she should still consider joining a Part D plan. If a beneficiary does not have creditable coverage (coverage for prescription drugs that is at least as good as the standard Medicare Prescription Drug Coverage), they will have to pay a penalty if they choose to enroll later. Anyone who enrolls in Part D during the Part D Initial Enrollment Period (IEP) will not incur a late enrollment penalty.

Other people with creditable coverage, such as through a former employer or union, the Veterans Administration (VA), or TRICARE for Life, will not experience a penalty for late enrollment. The penalty is equivalent to one percent (1%) of the "base premium" (\$34.10 in 2016 per full month that the person with Medicare was not enrolled in a Medicare Prescription Drug Plan when first eligible, and did not have creditable coverage. This penalty needs to be paid for as long as you have Part D coverage. If the beneficiary has had creditable coverage with a gap of no more than 63 days from when that coverage ended and the Medicare Part D coverage begins, they will not be subject to a penalty. There is no late enrollment penalty for people with full or partial Extra Help.

Cost Utilization Management Tools

In an effort to control costs, Medicare Prescription Drug Plans employ the following cost utilization management tools— Tiers, Prior Authorization, Step Therapy, and Quantity Limits.

- **Tiers:** Most Part D plans divide their formulary (list of covered medications) into "tiers" and encourage the use of drugs covered under a lower tier by assigning different co-payments or coinsurance for the different tiers. Generally, generic drugs fall under a lower tier and cost less than drugs covered under a higher tier, such as brand-name medications.
- **Prior Authorization:** Although a plan may cover a medication in its formulary, they may require that a doctor contact the plan to explain the medical necessity for that particular drug.
- **Step Therapy:** A Part D plan may require a beneficiary to try less expensive drugs for the same condition before they will pay for a more expensive, brand

- 入住、居住或離開長期護理設施者，包括專業護理設施。
- 退出雇主/工會所提供之保險 (包括 COBRA)，以登記參加 D 部分計畫。
- 處方藥計畫撤出服務地區。

申請加入聯邦醫療保險 D 部分計畫有幾種方式：

- 上網以電子方式申請，可至 www.medicare.gov 或該計畫的網站。HIICAP 可協助您進行在線登記。
- 以電話申請，可致電 1-800-MEDICARE 或直接致電該計畫。
- 親自申請，於預訂的家庭訪問期間或是在銷售/行銷活動中，透過 D 部分計畫的代表申請。

延遲登記罰金

即使擁有聯邦醫療保險者目前很少用到處方藥，他們仍應該考慮加入 D 部分計畫。若受益人沒有可替代承保 (對處方藥的承保範圍至少與標準的聯邦醫療保險處方藥承保範圍相當)，而他們選擇延後加入，則必須支付罰金。凡是在 D 部分計畫首次參加期 (IEP) 期間登記加入 D 部分計畫者，將不會有延遲登記罰金。

其他擁有可替代承保的人士，例如透過前雇主或工會、退伍軍人事務部 (VA) 或軍人醫療保險 (TRICARE for Life)，將不會因為延後加入而面臨懲罰。在首次合格時擁有聯邦醫療保險者未登記加入聯邦醫療保險處方藥計畫，也沒有可替代承保，其每月罰金相當於「基本保費」(2016 年為 \$34.10) 的百分之一 (1%)。只要擁有 D 部分保險就必須支付此項罰金。若受益人擁有可替代承保，而在該保險終止與聯邦醫療保險 D 部分保險開始時的缺口少於 63 天，即無須繳交罰金。領取全額或部分額外補助的人士也無延遲登記罰金。

成本利用管理工具

為了控制成本，聯邦醫療保險處方藥計畫運用下列成本利用管理工具 — 藥品分級、事前授權、循序用藥及數量限制。

- **藥品分級：**大部分的 D 部分計畫都把藥物及費用計算清單 (承保的藥品列表) 劃分「等級」，並以不同等級的藥品有不同的共付額或共保額的方式，鼓勵使用較低等級的承保藥品。一般來說，與原廠品牌藥之類較高等級的承保藥物相比，非原廠等同藥屬於較低等級且成本較低。
- **事前授權：**雖然保險計畫可能承保其藥物及費用計算清單的藥品，仍可能會要求醫生與該計畫聯絡，以說明使用該特殊藥物的醫療必要性。

name medication. However if a beneficiary has already tried the less expensive drugs they should speak to their doctor about requesting an exception from the plan.

- **Quantity Limits:** For safety and cost reasons, plans may limit the quantity of drugs that they cover over a certain period of time. For instance, a plan may only cover up to a 30-day supply of a drug at a time.

How Do I Select a Part D Plan?

To select a Part D plan for your specific needs, it is best to use the personalized plan finder tool at www.medicare.gov. You can either do a "Personalized Search," whereby you input your personal Medicare information, or a "General Search," for which you don't need any of your personal Medicare information.

You will input the names of the medications you are currently taking or expect to take in the upcoming year, along with the dosages and quantities needed for a 30-day supply. It is best to ask for a listing of your medications from your pharmacist before you start this process.

You will be asked to select up to two pharmacies that you would like to include in your search. After you have input all of the information, the plan finder will provide a listing of the Part D plans, sorted from least expensive to most expensive. It is important to look at the details of each plan to understand what cost utilization management tools, if any, may apply. It is also advised to call up the plan to verify the information.

When you have selected the plan that's right for you, you can enroll online or by calling Medicare (1-800-MEDICARE) or the Part D plan. If you would like help using the plan finder, please contact a HIICAP counselor by calling 311 and asking for HIICAP.

Do I need a Part D Plan if I Have Employer Health Coverage?

You may not need to enroll in a Part D plan if you have creditable drug coverage through a current or former employer. The current or former employer should advise you, usually through a letter, as to whether your drug coverage is creditable and whether or not you should enroll in a Part D plan. If you do not receive a letter, contact the employer to determine if you should enroll in a Part D plan. This is vital, since enrollment in a Part D plan may compromise all health benefits through that employer, not just prescription drug coverage.

Do I Need a Part D Plan if I Don't Take any Medications?

Having a Part D prescription drug insurance plan is optional, though it is important to remember that most people can only sign up for a plan during the Annual Election Period (AEP), from October 15 - December 7 of each year. It may be advisable to explore the least expensive plan in case your drug needs change in the coming year. Also remember that you may face a late enrollment penalty if you do not enroll when you are first eligible.

- **循序用藥：**D 部分計畫可能要求受益人先試用較便宜的藥品以治療同一病症之後，他們才會支付較昂貴的原廠品牌藥。不過，若受益人已經試過較便宜的藥品，他們應該與醫生討論對該計畫提出破例要求。
- **數量限制：**基於安全與成本因素，保險計畫可能會對在一定期間內賠付的藥品數量加以限制。例如，保險計畫對於一種藥品的賠付可能一次最多為 30 天用量。

如何選擇 D 部分保險計畫？

欲選擇 D 部分保險計畫以滿足您的特殊需要，最好是使用個人化計畫搜尋工具，請至 www.medicare.gov。您可以輸入個人的聯邦醫療保險資料以進行「個人化搜尋」，或是不需要任何個人聯邦醫療保險資料的「一般搜尋」。

您需要輸入目前正在服用的藥物名稱，或是來年預期將服用的藥物名稱，以及劑量和 30 天用量所需的總量。在展開此項程序之前，最好先向藥劑師索取一份您的用藥清單。

過程中會要求您選擇至多兩家藥房納入搜尋。在輸入全部資料之後，計畫搜尋器將提供一份 D 部分保險計畫列表，依價格最低至最高者排列。仔細查看每項計畫的細節以瞭解所使用的成本利用管理工具(若有)是很重要的。同時也建議您致電該計畫以確認其資訊。

當您選妥適合自己的計畫之後，可以上網登記或是致電聯邦醫療保險 (1-800-MEDICARE) 或 D 部分計畫。若是需要協助使用計畫搜尋器，請致電 311 洽詢 HIICAP，聯絡 HIICAP 輔導員。

若是已有僱主健康保險，是否需要 D 部分計畫？

若透過現在或以前的僱主而擁有可替代的藥品保險，可能不需要加入 D 部分計畫。現在或以前的僱主應該會告知(通常是以信函方式)您的藥品保險是否可替代，以及您是否應該加入 D 部分計畫。若未收到此一信函，請聯絡僱主以決定您是否應該登記加入 D 部分計畫。這一點至關重要，因為登記加入 D 部分可能使透過該僱主所擁有的全部健康保險失效，並非僅是處方藥保險。

我若是未服用任何藥物，還需要 D 部分計畫嗎？

D 部分處方藥保險計畫是選擇性的，但很重要的的是必須牢記，大多數人只能在年度協調選擇期 (AEP) 期間登記加入計畫，此為每年 10 月 15 日至 12 月 7 日。建議不妨找出最便宜的計畫，以備來年的藥物需求有所變動。還要記住，若未在首次合格時登記加入，可能會面臨延遲加入的懲罰措施。

Extra Help with Drug Plan Costs for People with Limited Incomes

The Social Security Administration (SSA), through which people sign up for Medicare Parts A and B, subsidizes the cost of a Part D plan for Medicare beneficiaries with lower incomes and limited resources. The subsidy is paid directly to the Part D plan. The program is called the Low-Income Subsidy Program (LIS), also known as Extra Help.

Individuals with monthly incomes up to 135% of the Federal Poverty Level, \$1,337 (\$1,802 for couples), and resources up to \$8,780 (\$13,930 for couples) in 2016 may qualify for **full Extra Help**. Those qualifying for full Extra Help will not have a monthly premium for their Part D plan, as long as the plan selected is considered a “benchmark” plan. A benchmark plan is a Part D plan that has been designated by Medicare to meet certain coverage requirements and has a monthly premium that is fully subsidized by Extra Help (monthly premium up to \$39.73 in 2016). In 2016, there is a “de minimis” amount of \$2, meaning that if the plan’s premium is up to \$2 over the benchmark amount, the beneficiary may not be responsible to pay that amount, so long as the plan agrees to forego payment of the additional premium. Individuals with full Extra Help will not be subject to the plan’s deductible. Full Extra Help beneficiaries with incomes up to 100% of the Federal Poverty Level QMB will have co-pays of \$1.20 for generic prescriptions and \$3.60 for brand name prescriptions. All others with full Extra Help will have co-pays limited to \$2.95 for generic prescriptions and \$7.40 for brand name prescriptions.

Individuals with monthly incomes up to 150% of the Federal Poverty Level, \$1,485 (\$2,003 for couples), and resources up to \$13,640 (\$27,250 for couples) in 2016 may qualify for **partial Extra Help**. Those with partial Extra Help will pay a monthly premium on a sliding scale based on their income. In addition, they will be responsible for a deductible of up to \$74 and reduced co-pays of 15% of drug costs until they reach catastrophic levels, after which they pay the standard co-pay amounts.

HIICAP counselors can help screen for eligibility for Extra Help, as can the Social Security Administration. Call 311 to find help near you, call SSA at 1-800-772-1213 (1-800-325-0778 TTY), or apply online at www.socialsecurity.gov. You may apply for Extra Help through SSA at any time and if you qualify, you will receive a Special Enrollment Period for selecting a Medicare Part D drug plan. Individuals with Extra Help will not be subject to a penalty for late enrollment in Part D.

There are cases where someone is eligible for Extra Help but not enrolled in a Part D plan – perhaps with Medicaid, SSI, or a Medicare Savings Program. The Limited Income Newly Eligible Transition (LINET) Program may be able to help. LINET can get you retroactive or temporary prescription drug coverage while you enroll in a Part D plan. You may need documentation of Best Available Evidence that you are eligible for Extra Help, such as a Medicaid award letter, a MSP award letter, or proof of SSI. LINET can be reached at 1-800-783-1307.

CALL 311 AND ASK FOR HIICAP

對收入有限人士之藥品保險計畫費用的額外補貼

社會安全局 (SSA)，亦即透過其登記加入聯邦醫療保險 A 部分和 B 部分的機構，同時也為低收入及資產有限的聯邦醫療保險受益人提供對 D 部分計畫費用的補貼。補貼金直接付予 D 部分計畫。該項計畫的名稱為低收入補貼計畫 (LIS)，亦即額外補助 (Extra Help)。

在 2016 年，個人月收入在聯邦貧窮線的 135% 以下，亦即 \$1,337（夫妻為 \$1,802），而且資產在 \$8,780 以下（夫妻為 \$13,930），可能有資格領取**全額額外補助**。符合全額額外補助資格者將無須為其 D 部分保險計畫繳交月保費，條件是所選擇的計畫應屬於「基準型」計畫。基準型計畫是指由聯邦醫療保險指定以符合某些特定的承保條件的 D 部分保險計畫，而且其月保費是由額外補助全額補貼 (2016 年的月保費上限為 \$39.73)。2016 年訂出 \$2 的「微不足道」金額，意指如果保險計畫保費超過基準金額的部分在 \$2 之內，只要該計畫同意放棄收取超出的保費，受益人便無須支付該金額。領取全額額外補助者將不受保險計畫的自付額約束。全額額外補助受益人的收入若在聯邦貧窮線的 100% 以下，其非原廠等同藥的共付額為 \$1.20，而原廠品牌藥為 \$3.60。其他領取全額額外補助者的共付額限定為非原廠等同藥是 \$2.95，而原廠品牌藥是 \$7.40。

2016 年，個人月收入在聯邦貧窮線的 150% 以下，亦即 \$1,485（夫妻為 \$2,003），而且資產在 \$13,640 以下（夫妻為 \$27,250），可能有資格領取**部分額外補助**。領取部分額外補助者將根據其收入而繳交遞減的月保費。此外，他們將必須負擔最高限為 \$74 的自付額，以及已降低的 15% 藥品費用共付額，直到他們達到重大傷病賠付水準為止，之後則須支付標準共付額。

HIICAP 輔導員能協助查核是否具有申請額外補助的資格，社會安全局也能提供協助。請致電 311 以尋找離您最近、能提供您協助的資源，或致電社會安全局 1-800-772-1213 (1-800-325-0778 聽障專線)，或上網申請請至 www.socialsecurity.gov。您隨時都可以透過社會安全局申請額外補助，如果符合資格，您將有特殊參加期以選擇聯邦醫療保險 D 部分藥品保險計畫。領取額外補助者將不會因延遲登記 D 部分而被處以罰金。

在某些情況下，有資格領取額外補助者但未登記加入 D 部分計畫——也許加入醫療補助、社會安全補助金 (SSI) 或聯邦醫療保險免保費計畫。收入有限人士新增資格過渡 (LINET) 計畫也許能提供幫助。加入 D 部分計畫時，LINET 可幫助您取得追溯性或臨時的處方藥保險。您可能需要提供可獲得的最佳證據的證明文件，以表明您有資格領取額外補助，如醫療補助資助證明、聯邦醫療保險免保費計畫 (MSP) 資助證明或社會安全補助金 (SSI) 證明。可致電 1-800-783-1307 聯絡 LINET。

請致電 311 洽詢 HIICAP

NEW YORK STATE EPIC PROGRAM (Elderly Pharmaceutical Insurance Coverage)

The Elderly Pharmaceutical Insurance Coverage program (EPIC) is New York State's prescription drug insurance program for New York State's senior citizens. If you are 65 years old or over, live in New York State, and have an income of up to \$75,000 for singles/\$100,000 for married couples, you may be eligible for EPIC. EPIC enrollees may purchase prescriptions at 4,500 participating pharmacies across New York State by showing their EPIC card.

EPIC covers Medicare Part D and EPIC covered drugs after any Part D deductible (if the member has one) is met. EPIC also covers approved Part D excluded drugs for members enrolled in Part D drug plans. Members pay a reduced price for prescriptions depending on the cost of the medication. For example: for a prescription costing between \$15 and \$35, they pay \$7. The highest co-pay is \$20, regardless of the regular price of the prescription.

EPIC is used to supplement Medicare Part D coverage to further reduce prescription drug expenses. You must be enrolled in a Medicare Part D drug plan to receive EPIC benefits. Individuals with full Medicaid are not eligible for EPIC; however, those with a Medicaid spenddown may still be eligible.

EPIC FEE AND DEDUCTIBLE PLANS

There are two plans within EPIC, the Fee Plan and the Deductible Plan. Applicants do not have a choice of which plan to join; EPIC makes this decision based on the individual's/couple's income.

EPIC's Fee Plan is for individuals with annual incomes up to \$20,000 and married couples with incomes up to \$26,000. To participate in the Fee Plan, participants pay the annual fee associated with their income. After paying the fee, participants pay the EPIC co-pay for their medications. Fees are based on the previous year's annual income and are paid quarterly. For example: a single person with an income of \$16,000 would be responsible for an annual fee of \$110. A couple with an income of \$24,000 would pay \$260 per person to participate in EPIC's Fee Plan.

EPIC pays the Part D monthly premium for Fee Plan members, up to \$39.73 per month in 2016. In addition, EPIC members with full Extra Help (see page 30) will have their EPIC fees waived.

紐約州老人藥品保險 (EPIC) 計畫 (老人藥品保險)

老人藥品保險計畫 (EPIC) 是紐約州針對老人實施的處方藥保險計畫。凡是年滿 65 歲以上，居住在紐約州，單身者收入在 \$75,000 以下／已婚夫妻收入在 \$100,000 以下，就有資格申請 EPIC。加入 EPIC 者只要出示他們的 EPIC 卡，就可以在紐約州 4,500 家加盟藥房購買處方藥。

在支付任何 D 部分自付額（若會員有自付額）之後，EPIC 承保聯邦醫療保險 D 部分和 EPIC 承保藥品。對於登記加入 D 部分藥品計畫的會員，EPIC 還承保獲准的 D 部分不承保藥品。會員支付的處方藥費用較低，降幅視藥品成本而定。例如：處方藥費用介於 \$15 和 \$35 之間，他們支付 \$7。最高共付額為 \$20，不論處方藥的原價為何。

EPIC 用於補充聯邦醫療保險 D 部分保險，以進一步降低處方藥費用。您必須登記加入聯邦醫療保險 D 部分藥品計畫，才能獲得 EPIC 賠付。擁有全額醫療補助的個人無資格參加 EPIC；但參加醫療補助抵降保費計畫的個人仍有資格參加 EPIC。

EPIC 年費計畫和自付額計畫

EPIC 分為兩種計畫，即年費計畫和自付額計畫。申請人不能決定要參加那一種計畫；EPIC 會根據個人/夫妻的收入來決定。

EPIC 的年費計畫是針對個人年收入在 \$20,000 以下和已婚夫婦年收入在 \$26,000 以下者。欲參加年費計畫，參加者須視其收入繳交年費。繳交年費之後，參加者須為他們的藥品支付 EPIC 共付額。年費是根據前一年的年收入而定，按季繳納。例如：收入為 \$16,000 的單身人士須繳交 \$110 的年費。收入為 \$24,000 的夫妻則須每人支付 \$260 以參加 EPIC 的年費計畫。

EPIC 為年費計畫會員支付 D 部分月保費，2016 年每月最高至 \$39.73。此外，取得全額額外補助（請見第 30 頁）的 EPIC 會員將免繳 EPIC 年費。

EPIC's Deductible Plan is for individuals with annual incomes between \$20,001 and \$75,000, and married couples with incomes between \$26,001 and \$100,000. To participate in the Deductible Plan, participants pay for their prescriptions until they meet their EPIC deductible amount, which is based on the previous year's income. After meeting the deductible, participants pay only the EPIC co-pay. For example, a single person with an income of \$23,000 must meet an annual deductible of \$580. For a married couple with an income of \$29,000, each person must meet an annual deductible of \$700. There is no fee to join the deductible plan.

EPIC pays the Part D monthly premium (up to \$39.73 per month in 2016) for Deductible Plan members with incomes up to \$23,000 single/\$29,000 married. Deductible Plan members with higher incomes must pay their own Part D premiums, but their EPIC deductible will be lowered by the annual cost of a basic Part D plan (approximately \$476.76 in 2016).

After a Deductible Plan member reaches his/her deductible, all that they will need to pay is the EPIC co-payments for covered drugs. Drug costs incurred in the Part D deductible phase cannot be applied to the EPIC deductible.

TIP EPIC members without Extra Help may want to look into a Part D plan without a deductible; EPIC does not cover prescription medications purchased during a plan's deductible period.

How Does EPIC Work with Medicare Part D?

New York law requires EPIC members to also be enrolled in a Medicare Part D plan (see Medicare Part D, page 26), so if someone cannot enroll in Part D for whatever reason, they are not eligible for EPIC.

You can enroll in EPIC at any time of the year. Even if you do not have a Part D plan at the time of EPIC enrollment, you can enroll in a Part D plan afterwards.

Part D coverage is primary and EPIC coverage is secondary. The enrollee pays the EPIC co-pay based on the amount remaining after the Part D plan pays, thus reducing the enrollee's costs. For example, if you are responsible for paying a \$20 co-pay for a drug using your Part D Plan and also have EPIC, you would pay the EPIC co-pay on a \$20 drug, which is \$7. In addition, EPIC will cover you after you have met any Part D deductible, including during the initial coverage level, the "donut hole" (the Part D coverage gap), and during catastrophic coverage, as long as the drugs are first covered by your Part D plan. Approved Part D excluded drugs can be covered by EPIC first for those enrolled in Part D drug plans. EPIC will be a secondary payer for Part D plan members who use EPIC participating mail order pharmacies, even if that mail order pharmacy is outside of NY State. (EPIC will not pay the out-of-state pharmacy for a drug not covered by the Part D plan.)

EPIC 的自付額計畫是針對年收入介於 \$20,001 和 \$75,000 的個人，以及年收入介於 \$26,001 和 \$100,000 的已婚夫婦。欲參加自付額計畫，參加者須自行支付他們的處方藥直至達到 EPIC 的自付額為止，該自付額是根據前一年的收入訂定。在達到自付額之後，參加者只須支付 EPIC 共付額。例如，年收入為 \$23,000 的單身人士必須達到 \$580 的年度自付額。至於年收入為 \$29,000 的已婚夫妻，每個人須達到的年度自付額為 \$700。參加自付額計畫無需繳費。

EPIC 為收入不高於 \$23,000 的個人/\$29,000 的已婚夫妻自付額計畫會員支付 D 部分月保費（2016 年每月最高至 \$39.73）。收入更高的自付額計畫會員必須支付自身的 D 部分保費，但其 EPIC 自付額的降幅為基本 D 部分計畫的年度費用（2016 年約 \$476.76）。

自付額計畫會員達到他/她的自付額後，他們只需要支付承保藥品的 EPIC 共付額。D 部分自付額階段產生的藥品費用不能應用於 EPIC 自付額。

要領 不享受額外補助（Extra Help）的 EPIC 會員可能需要一份無自付額的 D 部分計畫；EPIC 不承保免賠期間購買的處方藥。

EPIC 如何與聯邦醫療保險 D 部分搭配運用？

紐約法律要求 EPIC 會員還須登記加入聯邦醫療保險 D 部分計畫（請見聯邦醫療保險 D 部分第 26 頁），若有人因故不能登記加入 D 部分，則其無資格參加 EPIC。

您可以在一年中的任何時候登記加入 EPIC。即使您在登記加入 EPIC 之時並無 D 部分計畫，您可在之後登記加入 D 部分計畫。

D 部分保險是主保險，EPIC 保險是副保險。參加者是根據 D 部分保險計畫支付後的餘額來支付 EPIC 共付額，因此可以降低參加者的負擔。例如，若您使用 D 部分保險計畫而應為藥品支付 \$20 共付額，而您同時也有 EPIC，則藥品費用以 \$20 作計算，最後您只需支付 \$7 的 EPIC 共付額。此外，只要藥品獲得 D 部分計畫的初級承保，在您達到任何 D 部分自付額後，EPIC 將對您承保（包括初級承保範圍「空窗部分」（D 部分保障缺口）期間以及重大傷病賠付期間）。對於登記參與 D 部分藥品計畫的人，核准的 D 部分不承保藥品可首先獲得 EPIC 承保。對於使用 EPIC 加盟郵購藥房的 D 部分計畫會員，即使郵購藥房不在紐約州，EPIC 亦將做為副保險賠付。（對於 D 部分計畫不承保的藥品，EPIC 將不會付款給位於他州的藥房。）

EPIC is New York State’s “SPAP” (State Pharmaceutical Assistance Program). SPAP members have a Special Enrollment Period (SEP), which allows you to enroll in or switch Part D plans (either a Medicare Advantage plan with Part D coverage, or a stand-alone Part D plan) one additional time each year.

EPIC and Extra Help

EPIC members who appear to be income eligible for Extra Help for paying for Medicare Part D costs (see page 30) are required to complete an additional form called Request for Additional Information (RAFI) so that EPIC can apply to the Social Security Administration for Extra Help on their behalf. The application for Extra Help will also be submitted to New York State’s Medicaid program to assess eligibility for a Medicare Savings Program (see page 35) to help pay for the Medicare Part B premium.

Co-payments for Medicare Part D and EPIC covered or approved Part D excluded drugs:

Prescription Cost (after submitting to Medicare Part D plan)	EPIC Co-Payment
Up to \$ 15	\$ 3
\$ 15.01 to \$ 35	\$ 7
\$ 35.01 to \$ 55	\$ 15
Over \$ 55	\$ 20

EPIC and Employer/Retiree Drug Coverage

EPIC requires Part D plan enrollment; individuals with employer/retiree drug coverage are likely to not also have EPIC, since enrollment in a Part D plan would most likely compromise their employer/retiree coverage. However, sometimes the employer/retiree drug coverage is actually considered to be a type of Part D plan, in which case the individual could also have EPIC. **Check with the benefits manager to find out what drug coverage you have.**

Applying for EPIC

- You can call EPIC at 1-800-332-3742 (TTY: 1-800-290-9138) to request an application.
- Visit www.health.ny.gov/health_care/epic/application_contact.htm to download and print an application. You can also submit an online request for EPIC to mail you an application.
- Fax the completed EPIC application to 518-452-3576, or mail the completed application to EPIC, P.O. Box 15018, Albany, NY 12212-5018.

CALL 311 AND ASK FOR HIICAP

EPIC 是紐約州的「SPAP」（州藥品協助計畫）。SPAP 會員擁有一個特殊參加期 (SEP)，該期間允許您每年可再一次登記加入或轉換 D 部分計畫（含 D 部分保險的一項聯邦醫療保險優勢計畫或單行的 D 部分計畫）。

EPIC 與額外補助

EPIC 會員的收入若符合資格申請額外補助以支付聯邦醫療保險 D 部分費用 (請見第 30 頁)，則必須填寫另一份名為「索取更多資料」(RAFI) 的表格，如此 EPIC 即可代為向社會安全局申請額外補助。額外補助申請表也將遞交予紐約州醫療補助計畫，以評估是否符合聯邦醫療保險免保費計畫 (請見第 35 頁) 的資格，而可獲得支付聯邦醫療保險 B 部分保費的協助。

**聯邦醫療保險 D 部分和 EPIC 承保
或核准的 D 部分不承保藥品的共付額：**

處方藥費用 (在提交予聯邦醫療保險 D 部分計畫之後)	EPIC 共付額
\$15 以下	\$ 3
\$15.01 至 \$35	\$ 7
\$35.01 至 \$55	\$ 15
\$55 以上	\$ 20

EPIC 與僱主／退休藥品保險

EPIC 必備條件為加入 D 部分計畫；擁有僱主／退休藥品保險的人士將不能再擁有 EPIC，因為加入 D 部分計畫極可能影響其僱主／退休藥品保險。然而，有時僱主／退休藥品保險實際上被視為是一類 D 部分計畫，在這種情況下，個人還可以擁有 EPIC。請洽詢相關福利管理部門以瞭解藥品承保範圍。

申請 EPIC

- 您可致電 1-800-332-3742 (聽障專線：1-800-290-9138) 向 EPIC 索取申請表。
- 造訪網站 www.health.ny.gov/health_care/epic/application_contact.htm，下載並打印申請表。也可以上網索取，請 EPIC 郵寄一份申請表給您。
- 將填妥的申請表傳真至 518-452-3576，或將填妥的申請表郵寄至 EPIC, P.O. Box 15018, Albany, NY 12212-5018。

請致電 311 洽詢 HIICAP

NEW YORK CITY SPONSORED PRESCRIPTION DRUG PROGRAMS

BigAppleRx

BigAppleRx is a free New York City sponsored prescription drug discount card. The Big Apple Rx card is free and available to everyone living in, working in or visiting the City, regardless of age, income, citizenship or health insurance status. No personal information or enrollment is required to use the card. The card is accepted at more than 2,000 pharmacies, including chain and independent stores throughout the five boroughs. Only one card is needed per family and there is no limit as to how many times the card can be used.

The card is not insurance. When the card is presented at a participating pharmacy, a discount is taken off the regular price of the prescription. Consumers can save up to 15% on brand name drugs and 53% on generics. Discounts also apply to over-the-counter medications such as smoking cessation aids and diabetic supplies with a doctor's prescription. Cardholders can also purchase prescription through a mail order service and at participating pharmacies nationwide.

The card cannot be used in combination with any other discount card or with insurance. However, it can be used to get medications that the user's insurance does not pay for, or to purchase items that would be less expensive using the card than using the consumer's prescription drug insurance plan. Those with Medicare Part D can use the card to save on prescriptions if/when they have to pay the full cost of their medications.

Receipts from using the Card might count toward meeting an insurance plan's deductible. Consumers should first check with their insurer to find out whether their plan would accept such receipts.

By visiting www.BigAppleRx.com or calling 311 or 1-800-697-6974, you can:

- Get more information on the BigAppleRx card.
- Get a card.
- Find a participating local pharmacy.
- Find out how much a prescription would cost using the card.

CALL 311 AND ASK FOR HIICAP

紐約市資助的 處方藥計畫

BigAppleRx

BigAppleRx 是由紐約市政府免費提供的處方藥折扣卡。Big Apple Rx 卡免費發放予在紐約市居住、工作或到訪的任何人士，無論其年齡、收入、公民身份或有無醫療保險。使用該卡無須提供個人資料，也無須登記。該卡可在超過 2,000 家藥房使用，包括遍佈於五個行政區的連鎖式或獨立經營的藥房。每一戶家庭只需要一張卡，而且該卡的使用次數沒有限制。

該卡並非保險。在參與該項計畫的藥房出示該卡時，可依處方藥的定價獲得折扣。消費者購買原廠品牌藥的優惠最高達 15%，非原廠等同藥則有 53% 的優惠。折扣優惠亦適用於成藥，例如戒菸輔助品及有醫生處方的糖尿病用品。持卡人也可以透過郵購服務購買處方藥，並且可在全國各地參與該計畫的藥房購買。

該卡不得與其他任何折扣卡或保險合併使用。然而，該卡可用於下列情況：用戶的保險不支付該藥品；或是與使用消費者的處方藥保險計畫相比，用該卡購藥較為便宜。擁有聯邦醫療保險 D 部分計畫者，若是 (或當其) 必須為其藥物支付全額費用時，可使用該卡以節省處方藥支出。

使用該卡的收據得以計入保險計畫的自付額。消費者應該先向保險機構進行查詢，瞭解自己的保險計畫是否接受這類收據。

造訪 www.BigAppleRx.com 或致電 311 或 1-800-697-6974，您就能：

- 瞭解關於 BigAppleRx 卡的詳情。
- 取得折扣卡。
- 查找參與該計畫的當地藥房。
- 瞭解使用該卡後的處方藥費用。

請致電 311 洽詢 HIICAP

MEDICARE SAVINGS PROGRAMS

Medicare Savings Programs (MSP) can help eligible clients pay for their Medicare premiums and other costs associated with Medicare. MSPs are administered by the Human Resources Administration (HRA) in New York City.

Below is information on the Medicare Savings Programs, followed by income and resource limits for each of the programs, and how to apply.

- **Qualified Medicare Beneficiary Program (QMB):** This program can pay for the Medicare Part A and/or Part B premium, as well as the coinsurance and deductibles for Parts A and B. An individual can be eligible for QMB only, or for QMB as well as Medicaid. Individuals with QMB should see providers who accept both Medicare and Medicaid if they want full Medical coverage with no out-of-pocket costs.
- **Specified Low Income Medicare Beneficiary Program (SLMB):** This program pays for the Medicare Part B premium. Individuals can be eligible for SLMB only, or for SLMB and Medicaid (with a spenddown). The applicant must have Medicare Part A in order to be eligible for SLMB.
- **Qualified Individual (QI):** This program pays for the Medicare Part B premium. Individuals cannot be eligible for both QI-1 and Medicaid. The applicant must have Medicare Part A to be eligible for QI-1.
- **Qualified Working and Disabled Individual (QWDI):** This program pays for the Medicare Part A premium only, not Part B. The applicant must be a disabled worker under age 65 who lost Part A benefits because of return to work.

2016 MSP Monthly Income and Resource Limits (after any deductions/exclusions)				
	Single		Married Couple	
	Income	Resources	Income	Resources
QMB: 100% FPL	\$990	No Limit	\$1,335	No Limit
SLMB: 120% FPL	\$1,188	No Limit	\$1,602	No Limit
QI: 135% FPL	\$1,337	No Limit	\$1,802	No Limit

Applying for a Medicare Savings Program

- MSP applicants can apply through a Deputized representative, at the local Medicaid office, or by mail.
- A Deputized Representative will assist you with completing the application and collecting the necessary supporting documents. To make an appointment with a deputized HIICAP counselor, call 311 and ask for HIICAP. You can also reach out to the Medicare Rights Center at 1-800-333-4114.
- Go to a local Medicaid office to submit your application. See page 67 for a list of local Medicaid offices.
- Mail your completed application and copies of supporting documents to: Medical Assistance Program; MSP-CREP, 5th Floor; P.O. Box 24330; Brooklyn, NY 11202-9801.

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險免保費計畫

聯邦醫療保險免保費計畫 (MSP) 能幫助符合資格的客戶支付他們的聯邦醫療保險保費及其他與聯邦醫療保險相關的費用。聯邦醫療保險免保費計畫是由位於紐約市的人力資源管理局 (HRA) 管理。

以下為聯邦醫療保險免保費計畫的資訊，之後則是每項計畫的收入、資產限制及如何適用。

- **合格的聯邦醫療保險受益人計畫 (QMB):** 本計畫可支付聯邦醫療保險 A 部分和/或 B 部分保費，以及 A 部分和 B 部分的共保額和自付額。個人可能只符合 QMB 的資格，也可能同時符合 QMB 和醫療補助的資格。擁有 QMB 者若想享有全額醫療賠付而無須負擔自付費用，就應該去看同時接受聯邦醫療保險和醫療補助的醫療業者。
- **特定低收入聯邦醫療保險受益人計畫 (SLMB):** 本計畫支付聯邦醫療保險 B 部分保費。個人可能只符合 SLMB 的資格，也可能同時符合 SLMB 和醫療補助 (抵降保費計畫) 的資格。申請人必須擁有聯邦醫療保險 A 部分才能有資格申請 SLMB。
- **合格個人計畫 (QI):** 本計畫支付聯邦醫療保險 B 部分保費。個人不能同時符合 QI-1 和醫療補助的資格。申請人必須擁有聯邦醫療保險 A 部分才能有資格申請 QI-1。
- **合格在職殘障人士計畫 (QWDI):** 本計畫只支付聯邦醫療保險 A 部分保費，不包括 B 部分保費。申請人必須是 65 歲以下的殘障勞工，因恢復工作而喪失了 A 部分的保險賠付。

2016 年聯邦醫療保險免保費計畫月收入及資產上限 (減去任何扣除額/抵免之後)				
	單身		已婚夫妻	
	收入	資源	收入	資源
QMB: 100% 聯邦貧窮線	\$990	不限	\$1,335	不限
SLMB: 120% 聯邦貧窮線	\$1,188	不限	\$1,602	不限
QI: 135% 聯邦貧窮線	\$1,337	不限	\$1,802	不限

申請聯邦醫療保險免保費計畫

- 聯邦醫療保險免保費計畫申請人可在當地醫療補助辦事處透過暫委代表或透過郵件申請。
- 暫委代表將協助您填妥申請表並收集所需的必要文件。欲約見 HIICAP 暫委輔導員，請致電 311 洽詢 HIICAP。您亦可致電 1-800-333-4114 洽詢聯邦醫療保險權益中心。
- 至當地醫療補助辦事處遞送您的申請表。請見第 67 頁的當地醫療補助辦事處一覽表。
- 請將您填妥的申請表及所需文件的副本一併寄至：Medical Assistance Program; MSP-CREP, 5th Floor; P.O. Box 24330; Brooklyn, NY 11202-9801。

請致電 311 洽詢 HIICAP

What Application Do I Use?

- If you are applying for an MSP only (not Medicaid and an MSP), you can use the simplified Medicare Savings Application form, the DOH-4328, at www.health.state.ny.us/health_care/medicaid/program/update/savingsprogram/msapp.pdf.
- If you are applying for both an MSP and Medicaid, you must use the Medicare Savings Application and the Access NY Health Care, DOH-4220 application found at <https://www.health.ny.gov/forms/doh-4220all.pdf>.

Medicare Savings Program Advocacy Tips:

- Individuals in an MSP are automatically eligible for full Extra Help for paying for Medicare Part D prescription drug coverage (see page 30).
- If you apply for Extra Help at a Social Security Administration you can be considered as applying for QMB, SLMB or QI-1. SSA will forward your information to New York State to be considered for MSP eligibility.
- You do not need to go to a Medicaid office to apply for an MSP.
- If you are working, you may still qualify for a Medicare Savings Program.

What Counts as Income when Applying for an MSP?

- Income includes wages from an employer or self-employment. It also includes funds that are received on a monthly basis, such as Social Security, pension, Veteran's Benefits, Unemployment Insurance, etc.
- There are certain income disregards which can reduce the amount of money that is counted when determining MSP eligibility. This can include health insurance premiums that are paid, for example: premiums for a Medicare Advantage Plan, Long Term Care Insurance premiums, retiree health insurance premiums, and dental insurance.

Note: The MSP program requires that you be collecting any Social Security benefits for which you are eligible.

使用哪種申請表？

- 若您只申請聯邦醫療保險免保費計畫（而非醫療補助及一項聯邦醫療保險免保費計畫），您可使用簡化的聯邦醫療保險免保費申請表，DOH-4328，網址為：www.health.state.ny.us/health_care/medicaid/program/update/savingsprogram/msapp.pdf。
- 若您同時申請聯邦醫療保險免保費計畫及醫療補助，您必須使用聯邦醫療保險免保費申請表及 Access NY Health Care，DOH-4220 申請表可在下列網址取得：<https://www.health.ny.gov/forms/doh-4220all.pdf>。

聯邦醫療保險免保費計畫宣導要領：

- 擁有聯邦醫療保險免保費計畫者，自動符合領取全額額外補助的資格，以支付聯邦醫療保險 D 部分處方藥保險（請見第 30 頁）。
- 若您在社會安全局申請額外補助，您可被視作申請 QMB、SLMB 或 QI-1。社會安全局將向紐約州遞送您的資訊，以考察是否符合聯邦醫療保險免保費計畫的資格條件。
- 您無須至醫療補助辦事處去申請聯邦醫療保險免保費計畫。
- 如果您在職，仍有資格申請聯邦醫療保險免保費計畫。

申請聯邦醫療保險免保費計畫 (MSP) 時，哪些可計為收入？

- 收入包括來自於雇主或自雇發放的薪資。其也包括每月領取的資金，如社會保險、養老金、退伍軍人福利、失業保險等。
 - 某些收入將不被計入，當決定聯邦醫療保險免保費計畫 (MSP) 資格時，被計入的金額會被減少。其可包括已支付的健康保險費，例如：聯邦醫療保險優勢計畫保險費、長期護理保險費、退休人士健康保險費及牙科保險。
- 註：**聯邦醫療保險免保費計畫 (MSP) 要求您領取您有資格獲取的任何社會安全福利。

MEDICARE FRAUD AND ABUSE

The federal government estimates that billions of dollars--approximately ten percent of the Medicare dollars spent--are lost through fraud, waste and abuse. Medicare beneficiaries are encouraged to be alert to, and report, any suspicious billing charges.

What is Fraud?

Fraud is the act of obtaining, or attempting to obtain, services or payments by fraudulent means—intentionally, willingly and with full knowledge of your actions. Examples of fraud are:

- Kickbacks, bribes or rebates.
- Using another person's Medicare card or number to obtain services.
- Billing for items or services not actually provided.
- Billing twice for the same service on the same date or different date.
- Billing for non-covered services, such as dental care, routine foot care, hearing services, routine eye exams, etc. and disguising them as covered services.
- Billing both Medicare and another insurer, or Medicare and the patient, in a deliberate attempt to receive payment twice.

What is Abuse?

Abuse can be incidents and practices which may not be fraudulent, but which can result in losses to the Medicare program. Examples of abuse are:

- Over-utilization of medical and health care services.
- Improper billing practices.
- Increasing charges to Medicare beneficiaries but not other patients. Not adjusting accounts when errors are found.
- Routinely waiving the 20% co-insurance and deductibles.

Medicare Do's and Don'ts

- Never give your Medicare number to people you don't know.
- Beware of private health plans, doctors and suppliers who use unsolicited telephone calls and door-to-door selling as a way to sell you goods and services.
- Be suspicious of people who call and identify themselves as being from Medicare. Medicare does not call beneficiaries and does not make house calls.
- Be alert to companies that offer free giveaways in exchange for your Medicare number.
- Watch for home health care providers that offer non-medical transportation services or housekeeping as Medicare-approved services.
- Be suspicious of people who claim to know ways to get Medicare to pay for a service that is not covered.
- Keep a record of your doctor visits and the processing of your bills by comparing the Medicare Summary Notice (MSN) and other coverage to the actual care.

CALL 311 AND ASK FOR HIICAP

聯邦醫療保險的詐騙與濫用

聯邦政府估計，因詐騙、浪費和濫用所造成的損失達數十億美元，約是聯邦醫療保險支出的 10%。因此鼓勵受益人對於任何可疑的收費保持警覺性並及時通報。

什麼是詐騙？

詐騙是指以欺詐的手段取得或企圖取得服務或款項，這些手段是故意的、出於自願的，並且完全清楚自己的行為。詐騙的例子包括：

- 回扣、賄賂或退款。
- 使用他人的聯邦醫療保險卡或號碼取得服務。
- 計費的項目或服務並未真正提供。
- 同樣的服務在相同日期或不同日期計費兩次。
- 計費的服務不在承保範圍內，例如：牙科護理、例行足部護理、聽力服務、例行眼科檢查等等，但卻假裝是承保的服務。
- 同時向兩方收取費用，例如：同時向聯邦醫療保險和另一家保險業者收費，或同時向聯邦醫療保險和病患收費，企圖重複收費。

什麼是濫用？

濫用的事件和作為可能並非詐騙，但可能導致聯邦醫療保險計畫的損失。濫用的例子包括：

- 過度使用醫療及健康護理服務。
- 不當的收費行為。
- 提高對聯邦醫療保險受益人的收費，但其他病患的收費不變。發現錯誤時並未更正帳戶的收費。
- 習慣性地免除 20% 共保額和自付額。

聯邦醫療保險注意事項

- 絕對不可以把自己的聯邦醫療保險號碼交給不認識的人。
- 特別注意私營健康保險計畫、醫生及相關業者利用電話行銷或上門推銷的方式向您銷售商品及服務。
- 持懷疑態度對待自稱是代表聯邦醫療保險的人士。聯邦醫療保險不會打電話給受益人，也不會登門造訪。
- 保持警覺性來面對提供免費禮物以換取聯邦醫療保險號碼的業者。
- 密切注意居家護理業者提供非醫療性交通服務或家事服務，而列為聯邦醫療保險核准的服務。
- 持懷疑態度對待宣稱有辦法讓聯邦醫療保險支付未承保服務的人士。
- 保存記錄，記載就醫看診的詳情，並在處理帳單時比對聯邦醫療保險摘要通知 (MSN) 和其他保險項目是否與實際接受的醫療護理相符。

請致電 311 洽詢 HIICAP

Be alert to:

- Duplicate payments for the same service.
- Services that you do not recall receiving.
- Services billed that are different from the services received.
- Medicare payment for a service for which you already paid the provider.

How to Report Medicare Fraud

If you believe health care fraud or abuse has been committed, call 1-877-678-4697. Detail as much of the following information as possible:

- Provider or company name and any identifying number next to his or her name.
- Your name, address and telephone number.
- Date of service.
- Type of service or item claimed.
- Amount approved and paid by Medicare.
- Date of the Medicare Summary Notice (MSN).
- A brief statement outlining the problem. Try to be as specific as possible. When Medicare beneficiaries assist Medicare in finding fraudulent or abusive practices, you are saving Medicare—and yourself—money.

**To report Medicare Fraud and Abuse,
Call SMP (Senior Medicare Patrol) at 1-877-678-4697.**

**To report Fraud & Abuse with Medicare Part D plans,
Call Medic at 1-877-7SafeRx.**

**Fraud and Abuse Are Everyone’s Problems and
Everyone Can Help!**

IDENTITY THEFT

The Federal Trade Commission offers information about how to protect your identity. Please contact the FTC for information or to make a complaint by calling 1-877-438-4338 or visiting www.consumer.gov/section/scams-and-identity-theft.

Please protect your Medicare number and Social Security number, as well as your date of birth, and any other personal information such as banking or credit card information. Be scrupulous and ask questions of those requesting this information from you and do not hesitate to inquire the legitimacy of their need for this information. Be an informed and proactive consumer.

CALL 311 AND ASK FOR HIICAP

以下狀況須提高警覺：

- 對同一項服務重複收費。
- 不記得曾接受過該項服務。
- 欲收費的服務與您所接受的服務不同。
- 您已付費予業者而聯邦醫療保險又為該項服務付款。

如何通報聯邦醫療保險的詐騙行為

若您確信有醫療保險的詐騙或濫用情事，請致電 1-877-678-4697。請盡量詳述下列資訊：

- 醫療業者或公司名稱，以及其姓名旁邊的任何識別號碼。
- 您的姓名、地址和電話號碼。
- 服務日期。
- 所申報的服務類別或項目
- 聯邦醫療保險所核准並賠付的金額。
- 聯邦醫療保險摘要通知 (MSN) 的日期。
- 簡要說明敘述問題。盡可能針對重點明確說明。聯邦醫療保險受益人協助聯邦醫療保險找出詐騙或濫用行為，不但是為聯邦醫療保險省錢，也是為您自己省錢。

欲通報聯邦醫療保險的詐騙和濫用，
請致電 SMP (老人醫療保險巡邏計畫)，電話為：1-877-678-4697。

欲通報聯邦醫療保險 D 部分計畫的詐騙及濫用，
致電 Medic 請撥打 1-877-7SafeRx。

**詐騙和濫用是大家的問題，
大家都能提供協助！**

身份盜用

聯邦貿易委員會提供關於如何保護身份資料的資訊。請洽詢聯邦貿易委員會，或致電 1-877-438-4338 或至 www.consumer.gov/section/scams-and-identity-theft 提出投訴。

請保護您的聯邦醫療保險號碼和社會安全號碼，以及您的出生日期和任何其他個人資料，例如：銀行或信用卡資料。對於向您索取這些資料者，須小心謹慎並提出疑問，並且詢問他們需要這些資料的合法性，不要遲疑。做一位掌握資訊且積極主動的消費者。

請致電 311 洽詢 HIICAP

MEDICAID

Medicaid is a joint federal, state and city government health insurance program for low-income individuals. Medicaid is a “means tested” program requiring applicants to prove their financial need in order to be eligible. Once determined Medicaid eligible, a permanent plastic Medicaid card is issued and is valid as long as he or she remains eligible. The enrollee uses it like a credit card for health care services at any medical facility that accepts Medicaid. Medicaid requires that you be a U.S. citizen or qualified alien. In order to apply for Medicaid in New York City, you must reside in New York City; you can apply in any borough.

Medicaid-Covered Services

- Emergency & Hospital Services
- Preventive Services
- Personal Care Services
- Case Management Services
- Approved Prescription Medication
- Physical Therapy
- Speech and Hearing Rehabilitation
- Tuberculosis (TB) Related Services
- Mental Health Services
- Private Duty Nursing
- Hearing aids
- Diagnostic Services
- Occupational Services
- Clinic Services
- Screening Services
- Rehabilitative Services
- Hospice Care
- Eyeglasses & Optometry Services
- Dental Services and Dentures
- Prosthetic Devices
- Transportation

Medicaid Expansion for certain groups under the Affordable Care Act - MAGI

Under the Affordable Care Act, New York State chose to expand Medicaid coverage to cover people with incomes at higher levels than previously allowed. This includes pregnant women, children up to age 18, parents/caretaker relatives, and childless adults ages 19-64. This group is subject to MAGI (Modified Adjusted Gross Income) budgeting. Beginning January 1, 2014, pregnant women and children can qualify for Medicaid with higher incomes; parents/caretaker relatives and childless adults will be able to have incomes up to 138% FPL (\$1,366 monthly for an individual/\$1,842 couple in 2016). There is no asset limit for this group. Individuals will receive their Medicaid benefits through a managed care plan, which should be selected at the time of application.

Individuals who are determined **disabled**, including those receiving Social Security Disability Insurance but not yet in receipt of Medicare, as well as individuals **age 65 and over who are parent/caretaker relatives** (even if receiving Medicare), may qualify for Medicaid at these higher MAGI levels.

醫療補助 (MEDICAID)

醫療補助是聯邦、州及市政府共同為低收入人士而開辦的健康保險計畫。醫療補助是須「經過經濟情況調查」的計畫，申請人必須證明他們的財務需要才能符合資格。一旦確定符合醫療補助資格，將發予一張永久性的塑膠製醫療補助卡，只要當事人仍符合資格就一直有效。加入者使用醫療補助卡就像信用卡一般，可至任何接受醫療補助的醫療設施接受醫護服務。必須是美國公民或符合資格的外籍人士才能申請醫療補助。必須居住在紐約市，才能在紐約市申請醫療補助；可以在任一行政區申請。

醫療補助承保的服務

- 急診及住院服務
- 預防性保健服務
- 個人護理服務
- 個案管理服務
- 核准的處方藥
- 物理治療
- 言語和聽力復健
- 結核病 (TB) 相關服務
- 心理健康服務
- 私人看護
- 助聽器
- 診斷服務
- 職能服務
- 門診服務
- 篩檢服務
- 復健服務
- 安寧療護
- 眼鏡及驗光服務
- 牙科服務和假牙
- 義肢輔具
- 交通

依平價醫療法為部分人士提供醫療補助擴大方案 — MAGI

根據平價醫療法，紐約州擴大醫療補助承保範圍以涵蓋收入高於以往許可標準的人士。此包括孕婦、18 歲以下子女、父母／血親，以及 19 歲至 64 歲且無子女的成年人。這類人士受到 MAGI（修正調整後年總收入）預算的約束。從 2014 年 1 月 1 日開始，孕婦和子女可符合醫療補助資格的收入提高；父母／血親及無子女的成年人收入可至聯邦貧窮線的 138% 以下（2016 年為個人每月 \$1,366／夫妻每月 \$1,842）。對此類人士無資產限制。他們的醫療補助福利將透過管理式醫療計畫取得，該計畫應於申請時選定。

經判定為殘障的人士，包括領取社會安全殘障保險但尚未取得聯邦醫療保險者，以及年齡在 65 歲以上的父母／血親（即使已有聯邦醫療保險），在 MAGI 水準提高後可能也有資格獲得醫療補助。

Individuals subject to MAGI budgeting can **apply** online at www.nystateofhealth.ny.gov. They can receive assistance from Navigators for the application process. For a listing of Navigators, visit www.healthbenefitexchange.ny.gov/IPANavigatorSiteLocations. You can also call the New York State Customer Service Center toll free at 1-855-355-5777.

Medicaid Eligibility for all other groups – Non-MAGI

The following are the income and asset criteria for all others who are age 65+, blind, or disabled.

The Affordable Care Act does not change the income and asset levels under which most people age 65+, blind, or disabled qualify for Medicaid. This group is known as non-MAGI. To qualify for Medicaid in 2016 single individuals can have a **maximum monthly income** of \$825 and assets of \$14,850 (plus \$1,500 burial fund). Married Couples can have a maximum monthly income of \$1,209 and assets of \$21,750 (plus \$3,000 burial fund).

There are certain **income deductions**, so even if your income is over these amounts, you are encouraged to apply. Additionally, if your income is over these amounts, you may be eligible to participate in Medicaid's Excess Income Program, whereby, each month, you spend down the amount by which you are over Medicaid's allowed amount, in order to have Medicaid coverage. Moreover, if your income is over Medicaid's allowed amounts, you may be eligible for a Medicare Savings Program to help pay the Medicare premiums and other costs associated with Medicare (see page 37 for more information).

Assets include cash, bank accounts, IRAs and stocks. Certain assets are not counted towards these limits, including your primary home, your automobile and personal belongings.

Non-MAGI individuals cannot use the online Exchange; they must complete and submit the Access NY Health Care application, form DOH 4220, as well as Supplement A. You can access the applications and instructions, in both English and Spanish, at <https://www.health.ny.gov/forms/doh-4220all.pdf>.

Where do I submit the application?

You have a choice of where and how to submit your Medicaid application:

- Go to your local Medicaid office—you can get help to complete the application in person at the office, or drop off a completed application. See page 67 for a list of Medicaid offices, or call the Human Resources Administration at 1-718-557-1399, or 311.
- Submit an application by mail. Mail the completed application along with supporting documents to:
Initial Eligibility Unit
HRA/Medicaid Assistance Program
P.O. Box 2798
New York, NY 10117-2273

受到 MAGI 預算約束的人士可以上網申請，網址為 www.nystateofhealth.ny.gov。申請過程可由導引員提供協助。欲瀏覽導引員名單，請至 www.healthbenefitexchange.ny.gov/IPANavigatorSiteLocations。您也可以致電紐約州客戶服務中心免費電話：1-855-355-5777。

所有其他人士的醫療補助合格條件 — 非 MAGI

以下為年齡在 65 歲以上、失明或殘障者的收入及資產標準。

平價醫療法未更改年齡在 65 歲以上、失明或殘障者申請醫療補助時的收入及資產合格標準。此類即為「非 MAGI」人士。在 2016 年欲符合醫療補助的資格，單身人士的月收入上限為 \$825，資產上限為 \$14,850（另加 \$1,500 葬儀金）。已婚夫妻月收入上限為 \$1,209，資產上限為 \$21,750（另加 \$3,000 葬儀金）。

另有某些收入扣除額，因此即使收入超過上述金額，仍歡迎申請。此外，若收入超過上述金額，可能有資格參加醫療補助的超額收入計畫 (Excess Income Program)，此為每個月消耗超過醫療補助所容許的金額部分，以便取得醫療補助的賠付。而且，若是收入超過醫療補助所容許的金額，您可能有資格申請聯邦醫療保險免保費計畫，以協助支付聯邦醫療保險的保費和其他與聯邦醫療保險相關的費用（請見第 37 頁瞭解詳情）。

資產包括：現金、銀行帳戶、個人退休帳戶 (IRA) 和股票。某些資產不在限制之內，包括：主要住宅、汽車和私人物品。

「非 MAGI」人士不能使用網上交易所；必須填寫並遞送 Access NY Health Care 申請表、DOH 4220 表格，以及附表 A。您可至下列網址取得申請表和說明書（英文和西班牙文版），網址為：<https://www.health.ny.gov/forms/doh-4220all.pdf>。

申請表應遞送至何處？

您可以選擇遞送醫療補助申請表的地點和方式：

- 至當地的醫療補助辦事處 — 您可在辦事處取得協助以親自填妥申請表，或投遞已填妥的申請表。請見第 67 頁的醫療補助辦事處一覽表，或致電人力資源管理局 1-718-557-1399，或 311。
- 郵寄申請表。請將填妥的申請表及所需文件一併寄至：
Initial Eligibility Unit
HRA/Medicaid Assistance Program
P.O. Box 2798
New York, NY 10117-2273

How Does Medicaid Interact with Medicare Part D?

Most people with Medicaid and Medicare (known as “dual eligibles”) are required to join a Part D plan and will automatically be enrolled in a benchmark plan if they do not sign up for a plan on their own. Dual eligibles can change plans as often as every month, with the new coverage effective the first of the following month. (Note: Individuals with Medicaid only do not enroll in a Medicare Part D plan.)

Dual eligibles are automatically enrolled in full Extra Help (see page 30 for more information) and will pay a reduced amount for the prescription medications. Dual eligibles with incomes under 100% of the Federal Poverty Level (FPL) will have co-pays of \$1.20 for generic prescriptions/\$3.60 for brand name prescriptions. Those with incomes over 100% FPL will have co-pays of \$2.95 for generic prescriptions /\$7.40 for brand name prescriptions. Duals will no longer pay co-pays once the total cost of covered drugs reaches the catastrophic level of \$6,680 in 2016.

Certain drugs, by law, are not covered by Part D, such as over-the-counter medications and vitamins. These will continue to be covered by Medicaid.

MANDATORY MEDICAID MANAGED LONG TERM CARE

New York State requires certain dual-eligibles (enrolled in both Medicare and Medicaid) who are certified for 120+ days of community-based long-term care services through Medicaid to be enrolled in managed care plans to receive their Medicaid home care benefits.

If you are required to enroll in a Managed Long Term Care plan, you will receive a packet in the mail from New York Medicaid Choice, telling you about your choices. You will have 60 days to enroll in a plan. If you don't select a plan for yourself, you will be automatically enrolled in a plan.

There are three **types** of plans from which to choose:

1. **Managed Long Term Care Plans (MLTC):** MLTC plans provide only long term care services that you now get through Medicaid, as well as a few other services, such as home modifications, non-emergency medical transportation, podiatry, audiology, dental and optometry. You will continue to use your current plan (i.e. your Medicare card, your Medicaid card, or your Medicare Advantage card) for all other Medicare and Medicaid services. If someone does not enroll in a managed long-term care plan on their own, they will be automatically enrolled into an MLTC plan.
2. **Medicaid Advantage Plus (MAPlus):** MAPlus plans provide ALL Medicaid AND Medicare services, including long-term care services. Members receive all Medicaid and Medicare-covered services from the same plan and must use in-network providers.

CALL 311 AND ASK FOR HIICAP

醫療補助與聯邦醫療保險 D 部分如何交互運作？

大部分同時擁有醫療補助和聯邦醫療保險者 (即「雙重資格」), 都必須加入 D 部分計畫, 並將自動參加基準計畫 (如果他們未自行登記參加計畫)。具雙重資格者可以每個月更改計畫, 新保險計畫於次月首日生效。(註: 只有醫療補助者不得參加聯邦醫療保險 D 部分計畫。)

具雙重資格者即自動加入取得全額額外補助 (請見第 30 頁以瞭解詳情), 為處方藥所支付的費用也將降低。具雙重資格者的收入若在聯邦貧窮線 (FPL) 的 100% 之下, 所負擔的共付額為非原廠等同藥 \$1.20/原廠品牌藥 \$3.60。收入超過 100% 聯邦貧窮線者的共付額為非原廠等同藥 \$2.95/原廠品牌藥 \$7.40。一旦承保藥品的總費用達到重大傷病賠付的水準 (2016 年為 \$6,680), 具雙重資格者即無須再負擔共付額。

依據法令, 某些藥品並不在 D 部分的承保範圍內, 例如非處方藥物和維他命。這些藥品將繼續由醫療補助承保。

強制性醫療補助管理的長期護理

紐約州要求某些有資格享有醫療補助 120 天以上社區長期護理服務的雙重資格者 (同時加入聯邦醫療保險和醫療補助) 加入管理式護理計畫, 以取得其醫療補助居家護理賠付。

若您需要加入管理式長期護理計畫, 您將收到紐約醫療補助選擇 (New York Medicaid Choice) 寄來的郵包, 其中將告知您選擇的相關資訊。您將有 60 天的時間加入一項計畫。若您不自行選擇一項計畫, 您將自動加入一項計畫。

有三種類型的計畫可供選擇:

1. **管理式長期護理計畫 (MLTC):** MLTC 計畫僅向您提供目前可從醫療補助獲取的長期護理服務以及少數其他服務, 例如居家護理改善、非緊急性醫療交通、足部醫療、聽覺病矯治、牙科護理及驗光服務。您將繼續使用您當前的計畫 (即您的聯邦醫療保險卡、醫療補助卡或聯邦醫療保險優勢卡), 獲取所有其他的聯邦醫療保險及醫療補助服務。不自行加入管理式長期護理計畫者, 將自動加入 MLTC 計畫。
2. **醫療補助加優 (Medicaid Advantage Plus, MAPlus):** MAPlus 計畫提供所有的醫療補助及聯邦醫療保險服務, 包括長期護理服務。會員可從同一計畫獲取由醫療補助及聯邦醫療保險承保的所有服務, 且會員必須使用網內的醫療業者。

請致電 311 洽詢 HIICAP

3. **Programs of All-Inclusive Care for the Elderly (PACEs):** PACE plans provide ALL Medicaid AND Medicare services, including long-term care services. Members receive all Medicaid and Medicare-covered services from the same plan and must use in-network providers. The PACE plans differ from MAPlus plans in that you must be at least 55 years old to join PACE and PACE plans provide service through a particular site, such as a medical clinic or a hospital.

How will Managed Care work for clients with a Medicaid Spenddown?

Many people have Medicaid with a spenddown to help them pay for Medicaid-covered home care services. These individuals will now pay their Medicaid spenddown to the health plan. If a member does not pay the spenddown, the plan can disenroll the member.

How Do I Select a plan?

1. First, decide what type of plan would best suit your needs (MLTC, MAPlus or PACE).
2. Ask your providers (home care agency, medical providers, etc.) what plans they participate in so that you can pick a plan that would allow you to continue to see your providers. For people who wish to enroll in a MAPlus or PACE plan, you also need to get your Part D prescription drug coverage through that plan; the planfinder, at www.medicare.gov, should have the prescription drug information for these plans online.
3. To enroll in the plan, call NY Medicaid Choice at 1-888-401-6582. NY Medicaid Choice should also be able to help you select a plan.

How will the plan determine how many hours of home care I will receive?

If you are in the process of selecting a plan, you can ask the plan to do an assessment so that you can have a written plan for the number of hours of home care that you would receive if you enroll in that plan.

What if I want to switch managed long term care plans?

You can switch plans whenever you want. Just call the plan you want to join. The change must be requested by the 19th of the month for the new plan to be effective the first of the following month. New York Medicaid Choice (Maximus) is handling enrollment for Medicaid Managed Long Term Care. They can be reached at 1-800-505-5678 or 1-888-401-6582.

Fully Integrated Duals Advantage (FIDA)

Dual eligible beneficiaries in partially capitated Managed Long Term Care plans (MLTC) and fully capitated Medicare Advantage Plus (MAPlus) plans were sent letters in late 2014 informing them of the FIDA program. FIDA is a new type of managed care plan that provides all Medicare and Medicaid covered services, including home care services and Medicare Part D drug coverage, in a single plan.

3. **老人全方位護理計畫 (PACE) :** PACE 計畫提供所有的醫療補助及聯邦醫療保險服務，包括長期護理服務。會員可從同一計畫獲取由醫療補助及聯邦醫療保險承保的所有服務，且會員必須使用網內的醫療業者。PACE 計畫與 MAPlus 計畫的不同之處在於，您必須至少達到 55 歲方能加入 PACE 計畫，且 PACE 計畫透過特定的營業點（例如醫療門診或醫院）提供服務。

管理式護理可如何用於參加醫療補助抵降保費計畫的客戶？

許多人士藉助醫療補助抵降保費計畫，支付醫療補助承保的居家護理服務。該等人士將需要在健康保險計畫中支付醫療補助抵降保費計畫。若會員不支付抵降保費計畫，該計畫可將該會員除名。

如何選擇計畫？

1. 首先，決定最符合您需求的計畫類型（MLTC、MAPlus 或 PACE）。
2. 徵詢您的醫療業者（居家護理機構、醫療服務提供方等）他們所加入的計畫，以挑選一個能繼續與您的醫療業者會面的計畫。希望加入 MAPlus 或 PACE 計畫之人士亦需透過該計畫獲取 D 部分處方藥保險；計畫搜尋器（www.medicare.gov）應在線上公佈該等計畫的處方藥資訊。
3. 欲加入該計畫，請致電 1-888-401-6582 洽詢紐約醫療補助選擇 (NY Medicaid Choice)。紐約醫療補助選擇亦應能助您選擇計畫。

該計畫如何決定我將獲得的居家護理時數？

若您正在選擇計畫，您可要求作一次計畫評估，得出有關您加入該計畫所獲居家護理時數的書面計畫。

若想轉換管理式長期護理計畫怎麼辦？

您可以隨時轉換計畫。只需致電洽詢您希望加入的計畫即可。變更必須於每月的第19日之前提交，新計畫將於下月首日開始生效。

紐約醫療補助選擇 (Maximus) 正在登記加入醫療補助管理的長期護理。相關聯絡電話為 1-800-505-5678 或 1-888-401-6582。

全面整合雙重利惠計畫 (FIDA)

參與部分按人均攤的管理式長期護理計畫 (MLTC) 與完全按人均攤的醫療補助特惠 (MAPlus) 計畫的雙重資格受益者已於 2014 年底收到信函，被告知 FIDA 項目。FIDA 是管理式護理計畫的一種新類型，於單個計畫內提供所有聯邦醫療保險及其所承保的服務，包括居家護理服務及聯邦醫療保險 D 部分藥品保險。

Enrollment in FIDA is optional, though it is important to make an informed decision within the time limit noted in the letters.

- You can select a FIDA plan and enroll in the plan by calling NY Medicaid Choice at 1-855-600-FIDA.
- You can opt out of FIDA and stay with your current plan for long term health care by calling NY Medicaid Choice 1-855-600-FIDA.

If you do not respond within the time limit stated in the letters sent, you may be “passively enrolled” into a FIDA plan that is offered by the same company as your current managed long term care plan. Note that you can disenroll from FIDA at any time, though you will need to select a Part D plan in order to maintain drug coverage.

FIDA enrollees will have no copays or deductibles, including for prescription drugs, though prescription drugs need to be on the plan’s formulary. In addition, they will not have to pay the Part B premium, regardless of whether they are enrolled in a Medicare Savings Program (see page 35). If you have Medicaid with a spenddown, you WILL have to pay the spenddown amount to the FIDA plan.

FIDA enrollees can switch FIDA plans at any time. Or they can disenroll from FIDA and go back to Original Medicare or Medicare Advantage at any time. If they disenroll from FIDA, they would need to enroll in a MLTC plan, as well as a Part D plan.

For more information on FIDA, call New York Medicaid Choice at 1-855-600-FIDA.

How Can I Get Help with Managed Long Term Care Plans?

The Independent Consumer Advocacy Network (ICAN) is New York State’s ombudsman program for people receiving long term care services through Medicaid managed care, including MLTC, MAPlus (Medicaid Advantage), PACE, mainstream Medicaid (with long term care services) and FIDA. ICAN can be reached at 1-844-614-8800.

加入 FIDA 是選擇性的，然而，重要的是，需要在信函所載期限內做出明智的決定。

- 您可以選擇一項 FIDA 計畫並致電紐約醫療補助選擇 (NY Medicaid Choice) : 1-855-600-FIDA 表明加入該計畫。
- 您可以選擇不參加 FIDA 並致電紐約醫療補助選擇 (NY Medicaid Choice) : 1-855-600-FIDA 表明繼續維持當前的長期健康護理計畫。

如您在發出信函所載期限內未作出回應，您可能將「被動加入」一項由您當前的管理式長期護理計畫的同一公司提供的 FIDA 計畫。請注意，您可以隨時退出 FIDA，然而您需要選擇一項 D 部分計畫，以維持藥品保險。

FIDA 參加者將不擁有共付額或扣除額，包括處方藥，儘管處方藥需列於計畫的處方集中。此外，FIDA 參加者也無需支付 B 部分保險費，無論其是否參與聯邦醫療保險免保費計畫（請見第 35 頁）。如您參加醫療補助抵降保費計畫，您將必須為 FIDA 計畫支付抵降保費。

FIDA 參加者可隨時轉換 FIDA 計畫。或其可隨時退出 FIDA 並恢復原有的聯邦醫療保險或醫療補助優勢計畫。如 FIDA 參加者退出 FIDA，其需要加入管理式長期護理計畫 (MLTC) 和 D 部分計畫。

欲瞭解更多關於 FIDA 的資訊，請致電紐約醫療補助選擇 (New York Medicaid Choice) : 1-855-600-FIDA。

如何從管理式長期護理計畫 (MLTC) 得到幫助？

獨立消費者維權網 (ICAN) 是紐約州的監察專員計畫，主要針對透過醫療補助管理式護理（包括 MLTC、MAPlus（醫療補助優勢）、老年人全方位護理計畫 (PACE)、主流醫療補助（帶有長期護理服務）以及 FIDA）接受長期護理服務的人士。可致電 1-844-614-8800 聯絡 ICAN。

VETERANS' BENEFITS AND TRICARE FOR LIFE

To receive health care at facilities operated by the Department of Veterans Affairs (VA), veterans must be enrolled with the VA. Veterans can apply for coverage at any time. Veterans are placed into a Priority Group (1-9) based on service history and financial information. Veterans who cannot afford to pay the cost of their care must provide the VA with financial information on their annual income and resources. Most non-service connected veterans and non-compensable 0% service-connected veterans are required to complete an annual means test or to agree to pay VA the applicable copayment. The means test is based on their family's income and net worth. The 2015 income and asset net worth threshold is \$80,000. If you are single and your income and net worth is \$12,868 or less, then you receive free VA prescriptions. If you are single and your income is \$31,978 or less and do not have a service connected illness, then you receive free VA Health care. To learn more about VA national income thresholds and calculate your specific geographic-based means test (GMT), go to their website at http://www.va.gov/healthbenefits/cost/income_thresholds.asp.

Veterans not eligible for free care are responsible for a co-payment. There are four basic types of copayments for veterans not eligible for free care:

1. **Medication:** Prescription copayment charges were established by Congress. Depending on one's Priority Group, the charge is \$8 or \$9 for each 30 day or less supply of medications provided on an outpatient basis for non service-connected conditions.
2. **Outpatient:** Copayments for primary care visits are \$15 and \$50 for specialty care visits.
3. **Inpatient:** Congress determined the appropriate inpatient copayment should be the current inpatient Medicare Deductible Rate for the first 90 days that you remain in the hospital plus a \$10 per diem charge. This is the full rate; many veterans qualify for a reduced rate for inpatient care.
4. **Long Term Care:** VA charges for Long Term Care Services vary by type of service provided and the individual veterans' ability to pay.

The VA cannot bill Medicare, so veterans with Medicare-only who are responsible for the co-pay for medical care will receive the appropriate charge for services. However, if there is a supplemental policy, the VA will bill the carrier first.

TRICARE Health Benefits provides coverage to the families of active duty service members, families of service members who died while on active duty, and retirees and their families, whether or not the veteran is disabled. TRICARE benefits consist of: TRICARE Prime, TRICARE Extra and TRICARE Standard. The programs differ on the use of a provider networks and cost sharing obligations. Most specialty services require prior authorization or referral.

CALL 311 AND ASK FOR HIICAP

退伍軍人的保險福利與軍人醫療保險 (TRICARE FOR LIFE)

欲在由退伍軍人事務部 (VA) 所經營之機構接受醫療護理，退伍軍人必須向退伍軍人事務部登記。退伍軍人隨時都可以申請保險。根據服務年資和財務狀況，退伍軍人會分配至優先小組 (1-9)。無法負擔其醫護費用的退伍軍人，必須向退伍軍人事務部提供其年收入和資產的財務資料。大部分非因公退伍軍人和不可求償 0% 因公退伍軍人都必須完成年度經濟狀況調查，或同意支付予退伍軍人事務部適用的共付額。經濟狀況調查是以退伍軍人的家庭收入和淨值為基礎。2015 年的收入和資產淨值門檻為 \$80,000。若是單身且收入和資產淨值未超過 \$12,868，即可取得免費的 VA 處方藥。若是單身且收入和資產淨值未超過 \$31,978，亦無因公傷病，則可獲得免費的 VA 醫療護理。欲進一步瞭解 VA 全國性收入門檻，並測算適用於您的地區經濟狀況調查 (GMT)，請造訪相關網站 http://www.va.gov/healthbenefits/cost/income_thresholds.asp。

不具免費醫療護理資格的退伍軍人須支付共付額。不具免費醫療護理資格的退伍軍人有四種基本型態的共付額：

1. **藥物治療：**處方藥共付額費用乃由國會制定。視其所屬的優先小組，以門診方式為非因公傷病而提供的藥物治療，每次不超過 30 天用量的藥物須支付費用 \$8 或 \$9。
2. **門診病人：**普通醫療門診共付額為 \$15，專科醫療門診共付額為 \$50。
3. **住院病人：**國會認為適當的住院共付額應該是住院的首 90 天依照現行的住院病人聯邦醫療保險自付額費率，再加上每日收費 \$10。此為全額費率；許多退伍軍人有資格以較低費率接受住院治療。
4. **長期護理：**退伍軍人事務部對長期護理服務的收費視所提供的服務類別和退伍軍人個人的付款能力而定。

退伍軍人事務部不能向聯邦醫療保險收費，因此只擁有聯邦醫療保險且必須為醫療護理負擔共付額的退伍軍人，將需要為服務支付適當費用。不過，若有補充保險，退伍軍人事務部將會先向該承保業者收費。

TRICARE 軍人醫療保險為現役軍人的家屬、因公殉職的軍人家屬，以及退休人員及其家屬 (不論退伍軍人是否殘障) 提供保險。TRICARE 保險計畫有以下三種：TRICARE Prime、TRICARE Extra 和 TRICARE Standard。各項計畫所使用的醫療業者網絡和費用分攤義務不同。大部分的專科醫療服務都需要事先認可或轉介。

請致電 311 洽詢 HIICAP

Military retirees (and their spouses) having served at least 20 years who are 65 years or older and are currently enrolled in Medicare Parts A and B are eligible for **TRICARE for Life (TFL)**. TFL is a premium-free managed health care plan that acts as a supplement to Medicare and includes the **TRICARE Senior Pharmacy** program. TFL can be used at the VA but since the VA cannot bill Medicare, the patient is responsible for paying Medicare's portion of the bill. For more information on TRICARE for Life call 1-866-773-0404 or visit www.tricare.mil.

Civilian Health and Medical Program (CHAMPVA) is a health insurance program for dependents of 100% permanently and totally disabled veterans. CHAMPVA has an annual deductible or \$50 per person or \$100 per family per calendar year. In addition, there is a 25% co-insurance. CHAMPVA does not maintain a provider listing. Most Medicare and TRICARE providers will also accept CHAMPVA (but be sure you ask the provider). If eligible for TRICARE, one cannot be enrolled in CHAMPVA. For more information on CHAMPVA, you can call the VA at 1-800-733-8387 or visit www.va.gov.

How Does VA Drug Coverage Interact with Medicare Part D?

VA coverage for prescription drugs is considered creditable, meaning it is as good as, or better than, Medicare Part D. It is possible to have both a Part D plan as well as VA drug coverage. If one chooses to forego Part D and then later wishes to enroll in Part D, there will be no penalty for late enrollment.

VA Dental Insurance Program (VADIP)

The VA currently provides comprehensive dental benefits to certain eligible veterans. However, there are many veterans who have not been able to access VA dental services due to lack of eligibility. The VA is starting a pilot project, partnering with two dental insurers, whereby veterans enrolled in the VA health care program and CHAMPVA program beneficiaries can purchase dental insurance. The dental plans have monthly premiums and copayments. For more information, go to www.va.gov/healthbenefits/vadip/ or call Delta Dental at 1-855-370-3303 or MetLife at 1-888-310-1681.

For more information on health VA benefits, call 1-877-222-8387 (open 7am to 7pm Central Time) or visit www.va.gov.

65 歲以上 (含) 且服務 20 年以上的軍方退休人士 (及其配偶), 目前參加聯邦醫療保險 A 部分和 B 部分計畫者, 有資格參加 **TRICARE for Life (TFL)**。TFL 是免保費的管理式健保計畫, 用以補充聯邦醫療保險之不足, 並且包含 **TRICARE 老人醫藥**計畫。TFL 可用於退伍軍人事務部的醫療機構, 但由於退伍軍人事務部不能向聯邦醫療保險收費, 病患有責任支付帳單中的聯邦醫療保險部分。欲進一步瞭解 TRICARE for Life, 請致電 1-866-773-0404 或造訪 www.tricare.mil。

平民健康醫療計畫 (CHAMPVA) 是為 100% 永久性完全殘障的退伍軍人受撫養親屬所設的醫療保險計畫。CHAMPVA 訂有年度自付額, 每一日曆年個人為 \$50 或全家為 \$100。另外, 還有 25% 共保額。CHAMPVA 並無醫療業者一覽表。大部分聯邦醫療保險和 TRICARE 的醫療業者都會接受 CHAMPVA (但務必先向醫療業者確認)。符合 TRICARE 資格者不能參加 CHAMPVA。欲進一步瞭解 CHAMPVA, 可致電退伍軍人事務部: 1-800-733-8387, 或造訪 www.va.gov。

VA 藥品保險與聯邦醫療保險 D 部分如何交互運作?

VA 處方藥保險為人所稱道, 此表示它不亞於、或更優於聯邦醫療保險 D 部分。同時擁有 D 部分計畫及 VA 藥品保險是可行的。若是原先選擇放棄 D 部分計畫, 而日後想要加入 D 部分, 將不會有延遲登記罰金。

VA 牙醫保險計畫 (VADIP)

VA 目前對符合資格的部分退伍軍人提供綜合牙醫保險賠付。不過, 有許多退伍軍人因資格不符而無法取得 VA 牙科服務。VA 正與兩家牙醫保險業者合作展開一項試辦計畫, 參加 VA 健保計畫的退伍軍人和 CHAMPVA 計畫的受益人可以購買牙醫保險。牙醫保險計畫須支付月保費和共付額。欲取得更多資訊, 請至 www.va.gov/healthbenefits/vadip/ 或致電 Delta Dental: 1-855-370-3303 或 MetLife: 1-888-310-1681。

欲進一步瞭解退伍軍人事務部的健康保險福利, 請致電 1-877-222-8387 (中部時間上午 7 時至下午 7 時開通) 或至 www.va.gov。

OTHER HEALTH COVERAGE OPTIONS FOR NEW YORKERS

COBRA

Federal law requires employers with 20 or more employees to offer COBRA as “continuation coverage” of employer-based health care coverage after you leave your job. In New York State, most people can get COBRA coverage for up to 36 months. COBRA can bridge the gap until you go on Medicare or take a new job that offers a health care plan. You can qualify for coverage if you retire, leave your job, get laid off, have your work hours cut, or as a result of the death or divorce from your actively working spouse. Election of continued coverage must take place within 60 days of the notification of COBRA rights. Premiums for COBRA are 102% of what the employer and employee together pay for the plan. Your spouse and dependents are also entitled to benefit from your COBRA coverage.

If you are on COBRA before you become Medicare eligible, COBRA generally stops when Medicare starts. If you are already eligible for Medicare and still working, you may elect COBRA when you stop working, but should enroll in Part B within 8 months following the month you start COBRA coverage in order to avoid Medicare’s late enrollment penalty. If you have both Medicare and COBRA, Medicare is primary and COBRA secondary.

****New York State of Health/Health Insurance Exchange****

New!

The Health Insurance Exchange is an organized marketplace for purchasing health insurance. In New York State, the Exchange is known as New York State of Health: The Official Health Plan Marketplace. Through the Marketplace, eligible New Yorkers can select a “Qualified Health Plan” (QHP) as a way of getting health insurance. Eligible individuals with lower incomes may qualify for federal subsidies to purchase insurance through the Marketplace.

In New York City, you must select a plan that serves your borough. Anyone who is a citizen or a legal permanent resident residing in New York can purchase a plan through the New York Marketplace. If you have Medicaid you do not need to purchase other health insurance. If you have Medicare you do not need to purchase health insurance through the Marketplace. People with Medicare generally CANNOT enroll in a Marketplace plan. Medicare beneficiaries cannot get a federal subsidy to purchase a plan. If you are receiving Social Security Disability Insurance (SSDI) and are in the 24-month waiting period for Medicare coverage to begin, you may want to look into a Marketplace plan. When you become Medicare eligible, you can drop your Marketplace plan (though you may want to explore supplemental coverage to help pay for what Medicare does not cover).

CALL 311 AND ASK FOR HIICAP

紐約人士的其他醫療保險選項

COBRA

聯邦法令規定，員工人數在 20 人（含）以上之雇主，必須在員工離職後提供 COBRA 作為雇主健康保險的「延續保障」。在紐約州，大多數人士獲得的 COBRA 保障最高可達 36 個月。COBRA 可銜接缺口，直到您取得聯邦醫療保險或找到提供醫療保險的新工作。若有下列情況即符合此項保險資格：退休、離職、解雇、工時刪減，或是從事工作的配偶死亡或離婚。對延續保障的選擇必須在發出 COBRA 權益通知的 60 天內進行。COBRA 的保費是雇主和員工兩方付予該計畫合計金額的 102%。配偶和受撫養親屬也可以享有 COBRA 的保險福利。

若在符合聯邦醫療保險資格之前享有 COBRA，當聯邦醫療保險開始生效時，COBRA 一般即會終止。若是已經符合聯邦醫療保險的資格，並且仍在工作，可在停止工作時選擇 COBRA，但是應該在 COBRA 保險開始月份後的 8 個月之內登記加入 B 部分，以避免聯邦醫療保險的延遲加入罰金。若是同時擁有聯邦醫療保險和 COBRA，聯邦醫療保險為主保險，COBRA 為副保險。

新項

****紐約州健保計畫/健康保險交易所****

健康保險交易所 (Health Insurance Exchange) 是專為購買健康保險而設的市場。在紐約州，交易所的名稱為「紐約州健保計畫：官方健康保險市場」(New York State of Health: The Official Health Plan Marketplace)。透過該市場，符合資格的紐約人士可挑選「合格的健保計畫」(QHP)，以此種方式取得健康保險。合格且低收入的人士可能有資格申請聯邦補貼，以便透過該市場購買保險。

在紐約市，必須挑選在您所屬行政區提供服務的計畫。凡是居住在紐約的公民或合法永久居民，都可以透過紐約市場購買保險計畫。如果已有醫療補助，便不需要再購買其他健康保險。如果已有聯邦醫療保險，也不需要透過市場購買健康保險。擁有聯邦醫療保險者一般不能參加市場提供的保險計畫。聯邦醫療保險受益人不能取得聯邦補貼以購買保險計畫。若是領取社會安全殘障保險 (SSDI) 並正處於聯邦醫療保險承保開始前的 24 個月等候期內，可能要考慮市場提供的保險計畫。當您符合聯邦醫療保險的資格時，可以取消市場的保險計畫（不過您可能會考慮用補充保險來幫忙支付聯邦醫療保險不承保的項目）。

請致電 311 洽詢 HIICAP

You do not need to enroll in other health insurance if you have comprehensive health insurance coverage through TRICARE, the Veterans Health Program, a plan offered by an employer, insurance that you have bought on your own that is at least at the Bronze level (as determined by the Marketplace-see below), or a grandfathered health plan that was in existence before the health reform law was enacted. If you are unsure whether your coverage is sufficient, it is best to reach out to your plan to verify.

Under the Federal Affordable Care Act, you cannot be denied health insurance on the basis of a pre-existing condition, you cannot be charged more for health insurance, and there cannot be waiting periods to receive care for pre-existing conditions. These rules apply to plans purchased through the Marketplace and outside the Marketplace.

There are many health insurance options available through the Marketplace in New York City. All plans offer comprehensive health coverage, with limits to cost sharing (copayments, annual deductibles and out-of-pocket limits). If your income is less than 400% of the federal poverty level (\$47,520 for individuals and \$97,200 for a family of four in 2016), you may be eligible for Medicaid or for a Federal subsidy in the form of a tax credit to help pay for the cost of a plan.

Plans are divided into **four “metal” tiers** – bronze, silver, gold and platinum. The metal tiers have different cost-sharing (deductibles, co-pays) requirements; Bronze plans have lower monthly premiums and higher cost-sharing requirements, and Platinum plans having higher monthly premiums and lower cost-sharing requirements.

Open enrollment for the Marketplace will take place from November 1, 2015 – January 31, 2016. People enrolled by December 15, 2015 will have coverage effective January 1, 2016. If you enroll by January 15, 2016, you will have coverage effective February 1, 2016. If you enroll January 16-January 31, coverage will be effective March 1, 2016. If you do not enroll by January 31, 2016, you will need to wait for the next annual open enrollment period to enroll. There are certain exceptions which would allow you to enroll mid-year, including losing current health insurance coverage.

There are several ways to learn more about Marketplace plans:

- Reach out to a “Navigator.” Navigators are organizations in your community who can help you with selecting a plan and enrolling in a plan. To find a navigator near you, go to www.healthbenefitexchange.ny.gov/IPANavigatorMap or call the Community Health Advocates at 1-888-614-5400.
- Contact New York State of Health, operated by Maximus, at 1-855-355-5777, Monday-Friday, 8 am–5 pm.
- Visit www.healthbenefitexchange.ny.gov.

如有下列情況，便不需要參加其他健康保險：已透過 TRICARE、退伍軍人健保計畫、雇主提供的健保計畫、自行購買至少為銅級（依健保市場界定，請見下文）的保險計畫，或在健保改革法實施前即已存在的祖父級健保計畫，而擁有綜合健康保險的承保範圍。若不確定自己的承保範圍是否足夠，最好是向您的保險計畫查詢確認。

根據聯邦平價醫療法，不得因已經存在的病症而拒絕提供健康保險，不能增加收費來提供健康保險，並且對於已經存在的病症不可有接受醫療護理的等候期。上述規定適用於透過健保市場購買或並非在健保市場購買的保險計畫。

紐約市健保市場提供眾多健康保險選項。所有的計畫都提供綜合健康保險，並有費用分攤限額（共付額、年度自付額及自付費用上限）。如果收入未超過聯邦貧窮線的 400%（2016 年的個人收入為 \$47,520，四口之家收入為 \$97,200），便可能有資格獲得醫療補助，或以稅收抵免的形式取得聯邦補貼，以幫忙支付保險計畫的費用。

保險計畫區分為四種「金屬」等級 — 銅、銀、黃金、白金。各金屬等級的費用分攤（自付額、共付額）條件互異；銅計畫的月保費較低而要求的費用分攤較高，白金計畫的月保費較高而要求的費用分攤較低。

開放登記：健保市場於 2015 年 11 月 1 日至 2016 年 1 月 31 日開放登記。在 2015 年 12 月 15 日之前登記加入者，保險將於 2016 年 1 月 1 日生效。若是在 2016 年 1 月 15 日之前登記加入，保險將於 2016 年 2 月 1 日生效。如果在 2016 年 1 月 16 日至 31 日之間登記加入，保險將於 2016 年 3 月 1 日生效。若未在 2016 年 1 月 31 日之前登記加入，將必須等到下一個年度開放登記期才能加入。某些特定例外狀況可能容許於年中登記加入，包括喪失目前的健康保險。

進一步瞭解健保市場計畫的各種途徑：

- 聯絡「導引者」。導引者屬於社區組織，他們能協助您挑選並登記加入保險計畫。欲尋找附近的導引者，請至 www.healthbenefitexchange.ny.gov/IPANavigatorMap 或致電社區健康維護者 (Community Health Advocates)：888-614-5400。
- 聯絡紐約州健保計畫（由 Maximus 經營），電話：1-855-355-5777，週一至週五上午 8 時至下午 5 時。
- 造訪網站：www.healthbenefitexchange.ny.gov。

People with a QHP (Marketplace plan) who become eligible for Medicare are generally advised to enroll in Medicare when first eligible and drop their QHP by notifying their plan at least 14 days before they want their coverage to end (timed with the start of their Medicare benefits). This is because:

- One cannot continue to get any premium subsidy or cost sharing reduction (to help pay for the QHP premium) after becoming Medicare eligible.
- Having a QHP does not extend one's time to enroll in Medicare. Late enrollment could mean a gap in coverage and a late enrollment penalty.

The beneficiary is responsible for enrolling in Medicare A, B and D during their Initial Enrollment Period (see pages 3-4 for more information) and dropping QHP coverage.

People who may want to carefully consider QHP versus Medicare are those who:

- Do not qualify for Premium Free Part A. They may get a premium subsidy or cost sharing reduction for QHP coverage, but only if they don't enroll in Part A or B. Should they wish to enroll in Medicare at a later time, would have a delay, as well as a late enrollment penalty for both Medicare A and B.
- Are under age 65 and have End Stage Renal Disease.

HHC Options

HHC Options is a program through the NYC Health and Hospitals Corporation that allows low and moderate income individuals and families to access health care through HHC's network of hospitals and health facilities on a sliding fee scale. There is no charge to participate in HHC Options; you only pay when you access care. HHC does not look at immigration status when determining eligibility. For more information, visit <http://www.nychhc.org/hhc/html/patients/ForPatients-Paying-Options.shtml> or call 311 and ask for HHC.

Federally Qualified Health Centers

Federally Qualified Health Centers are comprehensive health centers that can provide primary care (both well and sick visits), mental health and substance abuse treatment, dental care and prescription drugs to people of all ages. While FQHCs accept health insurance, they also see patients with no insurance on a sliding-fee scale, whereby patients pay according to their income. For Medicare beneficiaries, FQHCs can waive the annual Part B deductible and the 20% co-insurance if eligible. To locate a FQHC, visit www.hrsa.gov and enter your location at "Get Health Care" and then "Find a Health Center."

加入合格的保健計畫 (QHP) 且有資格申請聯邦醫療保險的人一旦符合資格，一般建議他們加入聯邦醫療保險。在他們想要退出（即他們開始成為聯邦醫療保險受益人的日期）的至少 14 天之前告知QHP這是因為：

- 具備參加聯邦醫療保險資格後不能繼續領取任何保費補貼或減少費用分攤（以幫助支付 QHP 保費）。
- 加入 QHP 並不能延長登記加入聯邦醫療保險的時間。延遲登記會造成保險無法銜接以及面臨延遲加入罰金。

受益人須在初始登記階段登記加入聯邦醫療保險 A、B 與 D 部分（更多資訊參見第 3-4 頁），並退出 QHP 保險。

可能需要認真考慮選用 QHP 還是聯邦醫療保險的人有：

- 不具備加入免保費 A 部分資格的人。他們可能領取保費補貼或減少 QHP 保險的費用分攤，但是僅限他們不登記加入 A 或 B 部分的情況。他們應期望延遲加入聯邦醫療保險，登記延期，並且延遲加入聯邦醫療保險 A 和 B 部分均有延遲登記罰金。
- 年齡小於 65 歲且患有末期腎臟疾病的人。

健康和醫院機構保險 (HHC Options)

「健康和醫院機構保險」是由紐約市健康及醫院總局所提供的計畫，讓中低收入的个人和家庭能夠透過 HHC 的醫院和醫療設施網絡，按遞減的收費標準來取得醫護服務。參加「健康和醫院機構保險」無需任何費用；只有使用醫療服務時才要付費。HHC 在進行資格認定時並不會查看移民身份。欲瞭解詳情，請至 <http://www.nychhc.org/hhc/html/patients/ForPatients-Paying-Options.shtml> 或致電 311 洽詢 HHC。

聯邦合格保健中心

聯邦合格保健中心是向所有年齡層次之人士提供普通醫療（健康和疾病門診）、心理健康及藥物濫用、牙科護理及處方藥物的綜合保健中心。聯邦合格保健中心 (FQHC) 接納健康保險，且視病患並無按遞減標準收費（病患按照各自收入支付保費）的保險。對於聯邦醫療保險受益人，FQHC 可免除 B 部分的年度自付額和 20% 的共保額（若合資格）。欲找尋 FQHC，請造訪 www.hrsa.gov 並在「尋求衛生保險」（"Get Health Care"）欄輸入您的所在地，然後「查找健康中心」（"Find a Health Center."）。

Health Insurance & Self Employment

Some professions offer group rate insurance. Please inquire with your former employer and/or any professional associate memberships to which you belong. Here are a few resources to explore whether or not group plans may be available to you.

Small Business Service Bureau	Small business employee	1-800-343-0939 www.sbsb.com
Graphic Artists Guild	Graphic Artists	1-212-791-3400 www.gag.org
National Writers Union	Writers	1-212-254-0279 www.nwu.org
Screen Actors Guild	Performers	1-212-944-1030 www.sagaftra.org
Freelancer's Union	Financial Services Nonprofits Technology Media & Advertising Arts, Culture or Entertainment Domestic Child Care Giver Traditional or Alternative Health Care Provider Skilled Computer User	1-800-856-9981 www.freelancersunion.org

健康保險與自雇

有些行業提供團體費率的保險。請洽詢您的前任雇主和/或任何您所屬的專業協會。以下提供一些資源，可查詢是否有適合您的團體計畫。

小型企業服務局 (Small Business Service Bureau)	小型企業員工	1-800-343-0939 www.sbsb.com
平面藝術家協會 (Graphic Artists Guild)	平面藝術家	1-212-791-3400 www.gag.org
全國作家聯盟 (National Writers Union)	作家	1-212-254-0279 www.nwu.org
演員工會 (Screen Actors Guild)	表演工作者	1-212-944-1030 www.sagaftra.org
自由工作者聯盟 (Freelancer's Union)	金融服務 非營利事業 科技媒體與廣告藝術、文化 或娛樂 家庭托兒業者 傳統或另類醫療業者 專業電腦用戶	1-800-856-9981 www.freelancersunion.org

PATIENT RIGHTS AND APPEALS FOR MEDICARE BENEFICIARIES

All Medicare beneficiaries are protected by the same rights, whether you are in the original Medicare plan or a Medicare Advantage Plan.

As a Medicare beneficiary, you have the right to:

- Receive all the care necessary for your condition.
- Be fully informed about your medical condition, including treatment options. Learn about coverage and possible costs.
- Receive a written discharge plan from the hospital. Any decision made by the hospital or your HMO or PPO to discharge you must be based solely on your medical need and not on any method of payment.
- Appeal written notices denying coverage for services from hospitals, managed care plans (HMOs) or Medicare carriers.
- Ask for all notices in writing. DO NOT DISREGARD THEM. Any notice must describe how to appeal decisions.
- Under the new "Right to Know Law" in New York State, (the Palliative Care Information Act), every terminally ill New Yorker under a doctor's or surgeon's care will be offered full information about hospice care, palliative care for pain reduction and all other appropriate end-of-life options. You also have the right to refuse or withdraw life-sustaining treatment, to have pain medication and to learn more about treatment options.

To appeal a quality of care issue or question a hospital discharge, call Livanta, LLC at 866-815-5440, where trained staff will review your case before noon of the day after the beneficiary receives the notice. If you request immediate review by Livanta, you will not be financially responsible for additional hospital charges until noon of the day following your receipt of Livanta's review decision.

Medicare Advantage enrollees may use the plan's appeals process to appeal an inpatient stay denial or they can contact Livanta by noon of the day after the receipt of the NODMAR (Notice of Discharge and Medicare Appeal Rights). Other denied services may be appealed directly to the plan.

病患的權益與申訴 (適用於聯邦醫療保險受益人)

不論您是參加聯邦醫療保險原始計畫或是聯邦醫療保險優勢計畫，所有的聯邦醫療保險受益人都享有同樣的權利保護。

身為聯邦醫療保險受益人的權益有：

- 接受所有必要的醫療護理以治療病症。
- 充分獲知病情，包括治療選項。瞭解承保範圍和可能的費用。
- 從醫院處獲得書面的出院計畫。由醫院或您的 HMO 或 PPO 所做的任何出院決定，必須是完全根據您的醫療需求，而非受到任何付款方式的影響。
- 對醫院、管理式醫療計畫 (HMOs) 或聯邦醫療保險服務提供者拒絕承保服務的書面通知提出申訴。
- 要求所有的通知以書面方式提供。千萬別置之不理。任何通知都必須說明該如何對判決提出申訴。
- 在紐約州最新的「資訊透明法」之下 (安寧療護資訊法案)，接受醫生或外科醫生治療的每位身患絕症的紐約人士，都將會獲得充分資訊以瞭解安寧療護、減輕痛苦的緩和療護及其他適當的臨終關懷選項。您還有權利拒絕或撤除維生設備、選擇服用止痛藥物與瞭解更多治療選項。

欲對醫療品質問題提出申訴或對出院決定有疑問，請致電 Livanta, LLC：866-815-5440，受過專業訓練的工作人員將會在受益人收到通知後的次日中午前審查其個案。若是請求 Livanta 立即進行審查，在收到 Livanta 審查決定的次日中午之前，都無須負擔任何追加的住院費用。

參加聯邦醫療保險優勢計畫者，可以利用該計畫的申訴程序就住院遭拒提出申訴，或者可以在收到 NODMAR (出院和聯邦醫療保險申訴權利通知書) 後次日中午之前聯絡 Livanta。其他服務若遭拒絕可直接向該計畫提出申訴。

ADVANCE DIRECTIVES

Your Right to Make Health Care Decisions Under the Law

You have the right to make your own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatments, you should make these wishes known to your doctor, hospital or other health care providers. You have the right to be told the full nature of your illness, including proposed treatments, any alternative treatments and the risks of these procedures.

You need to speak with your spouse, family members, close friends and your doctor to help you decide whether you want an advance directive. Discuss with them, in advance, what your personal directions for your care would be.

An advance directive is a document that states your choices about medical treatment. In New York, there are three kinds of advance directives:

1. A Health Care Proxy allows you to appoint another person to make medical decisions for you should you become unable to make those decisions yourself. The "agent" you select needs to be clear about your wishes for treatment, be available if sudden choices need to be discussed, and agree to accept the responsibility if the situation arises. Typically, your doctor or hospital staff cannot be your "agent."
2. A Living Will allows you to explain your health care wishes and can be used to specify wishes regarding life-sustaining treatments or procedures administered to you if you are in a terminal condition or a permanent unconscious state. The document must be signed, dated and witnessed (but not by your doctor or a close relative).
3. A Do Not Resuscitate (DNR) Order allows you to specify that you do not want CPR should your heart or breathing stop.

Advance directives should be available in an emergency. Do not put them in a safe deposit box. Give a copy to each of your doctors and to the family member who might be your "agent." A copy is as good as an original. These forms are available at hospitals, doctor's offices and from state offices at www.ag.ny.gov. The forms are free and do not require a lawyer to complete.

Under the new Family Health Care Decisions Act, family members or a close friend can act as surrogate to make health care decisions, including withholding or withdrawal of life sustaining treatments on behalf of patients who have lost their ability to make such decisions and have not prepared advance directives regarding their wishes. Even with this new law, New Yorkers are encouraged to prepare a health care proxy which allows the person you appoint, called your "health care agent" to make health care decisions for an individual who loses the capacity to express those choices. Your agent must be aware of your wishes about nourishment and water through feeding tubes and IV lines.

CALL 311 AND ASK FOR HIICAP

預立醫療指示

法律所規定的個人醫療護理決定權

您有權利決定自己的醫療護理，包括接受、拒絕或停止何種醫療護理或治療。若是不想接受某種類型的治療，應該告知您的醫生、醫院或其他醫護業者。您有權利獲知所患疾病的全部詳情，包括：提議的治療方案、任何替代療法，以及這些過程所含有的風險。

您需要與配偶、家人、密友及醫生討論，以協助您決定是否應預立醫療指示。與他們預先討論，您對自己的醫療護理會有哪些個人指示。

預立醫療指示是一份文件，記錄您對醫療的選擇。在紐約，有三種預立醫療指示：

1. 醫療護理授權書 (Health Care Proxy) 讓您指定他人在您無法自行做決定時代您做出醫療決定。您所選擇的「代理人」必須清楚您對治療的期望，需要討論突發性抉擇時能夠取得連繫，並且同意在任何情況發生時能承擔責任。在一般情況下，您的醫生或醫院的工作人員不能成為您的「代理人」。
2. 生前預囑 (Living Will) 讓您能說明自己對醫療護理的期望，並可用於特別說明關於使用維生設備延長生命、或是在臨終或永久無意識狀態時所希望接受的處理程序。該份文件必須簽名、註明日期並有人證 (但不得為您的醫生或近親)。
3. 不施行心肺復甦術 (DNR) 指示讓您能特別指明一旦心臟或呼吸停止時，您不希望施行心肺復甦術。

預立醫療指示應該在緊急情況時可以取得。切勿把它們放在保險箱內。給您的醫生和可能成為您的「代理人」的家庭成員每人一份副本。副本和正本的效力是一樣的。這些表格可在醫院、醫生診所及下列網站上的州辦事處取得：www.ag.ny.gov。表格皆為免費且不需要律師即可填寫。

依照最新的家庭醫療決定法案，家人或密友能以代理人身份代為做出醫療決定，包括代表喪失決定能力、且未預先準備醫療指示表明態度的病患決定拒絕或撤除維生設備。儘管有這項新法令，建議紐約人士還是應該準備醫療護理授權書，讓指定的「醫療代理人」為失去表達選擇能力者做出醫療決定。代理人必須體察您對經由餵食管和靜脈注射給予營養與水份的意願。

請致電 311 洽詢 HIICAP

LONG TERM CARE PLANNING

Now that seniors are living longer, many have concerns about how they will manage health care needs and finances as they become less mobile. Long-term care—in one's home, in alternative housing or in a nursing facility—should involve planning. An understanding of the options and the kinds of care, and the financing of such care, will help give seniors greater control over these important issues in their later years. The following is an overview, topic by topic, of the long-term care planning and insurance areas of interest and concern.

What is Long-Term Care?

Long-term care is the kind of daily assistance that an older adult may need when dealing with a prolonged physical illness, a disability, or a cognitive impairment (such as Alzheimer's disease) that can leave a person unable to completely care for himself. Long-term care includes care in a nursing facility, as well as help at home with activities of daily living. Long-term care is generally divided into four categories:

1. **Skilled Nursing Care:** Daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel. The care must be ordered by a doctor.
2. **Intermediate Care:** Occasional nursing and rehabilitative care, which must be based on a doctor's orders, and can only be performed by, or under the supervision of, skilled medical personnel.
3. **Home Health Care:** Usually received at home as part-time skilled nursing care: speech therapy; physical or occupational therapy; part-time services from home health aides or help from homemakers or chore-workers.
4. **Custodial Care:** Care to help individuals meet personal needs such as walking, bathing, dressing, eating or taking medicine. It can usually be provided by someone without professional medical skills or training.

What are the Costs of Long-Term Care?

Arrangements for a home health aide on a private pay basis depend on the hours, level of services and skills required. If the health care provider comes from a certified home health agency where costs are paid through Medicare or Medicaid, the fees are set by the agency and government standards. Private care is \$20+ per hour for custodial services. Skilled care from therapists or visiting nurses, for example could cost \$100-150 per visit.

Nursing home costs in the New York City area average \$125,000-\$180,000 per year. An older adult requiring a nursing home placement must cover these costs either by paying from personal income and assets, having long-term care insurance or having Medicaid coverage.

CALL 311 AND ASK FOR HIICAP

長期護理規劃

現在的老年人都活得更長久，很多人關心等到活動力變差時，他們要如何處理醫療護理需求和財務問題。不論是要住在自己的家中、替代型老人住宅或是老人院，長期護理必須加以規劃。瞭解各種選項和醫護種類，以及這類醫護服務的資金安排，將有助於老年人更能掌控晚年的這些重大問題。以下即就長期護理規劃和保險方面引人注意及關切的事項，依主題逐一進行概述。

長期護理是什麼？

長期護理是指為有需要的老年人提供每日協助，他們可能是患有慢性疾病、殘障或認知能力障礙 (如阿茲海默氏症) 而無法妥善照料自己。長期護理包括在老人院的護理，以及在住家為日常生活的活動提供協助。長期護理一般可分為四類：

1. **專業護理：**提供每日護理和康復照護，只能由專業醫護人員進行或在他們的監督下進行。這類護理必須經由醫生作安排指示。
2. **中期護理：**偶爾提供護理和康復照護，必須根據醫生指示行事，而且只能由專業醫護人員進行或在他們的監督下進行。
3. **居家護理：**通常是在住家接受的部分時間性的專業護理：言語治療、物理或職能治療；由居家護理人員、管家或家事工提供部分時間性的服務。
4. **監護照護：**用以協助滿足個人需求的照護，例如：走路、沐浴、更衣、進食或服藥。一般可由不具專業醫療技術或訓練者提供此類照護。

長期護理的費用如何？

以私人付費方式所安排的居家護理人員是根據時數、服務等級和所需技能而定。若護理人員是來自於有證照的居家護理機構，而費用是透過聯邦醫療保險或醫療補助支付，則收費是由該機構依政府標準制定。監護照護服務的私人護理是每小時以 \$20 起計費。由治療師或探訪護士所提供的專業護理，每次探訪費可能為 \$100 至 \$150。

紐約市地區的老人院每年收費平均為 \$125,000-\$180,000。老年人若需要安置在老人院就必須負擔這些費用，費用可以是透過個人收入和資產、擁有長期護理保險或有醫療補助來支應。

請致電 311 洽詢 HIICAP

Who Pays for Long-Term Care?

Medicare

Medicare's coverage for long-term care is strictly limited by "medically necessary," prescribed circumstances.

Care in the Home is covered by Medicare when:

1. The care needed is intermittent skilled nursing care - physical therapy, occupational therapy, speech therapy, monitoring of condition, changing bandages, giving injections, and checking on equipment. "Intermittent" is defined as less than seven days per week, not to exceed 28 hours in any week. Medicare can approve more hours of care per week, but for a shorter period of time. Typically, Medicare approves on average of 8-12 hours of care per week.
2. The beneficiary is unable to leave his home except with the assistance of another person or a wheelchair, for example.
3. The doctor determines that the beneficiary needs home health care and prescribes a home health plan of treatment.
4. The services are provided by a Certified Home Health Agency (CHHA) participating in Medicare.

Care in a Skilled Nursing Facility is covered by Medicare when:

1. The beneficiary is admitted within thirty days after a minimum 3-day hospital stay.
2. The doctor documents that the patient requires a skilled level of care; custodial care can also be involved.
3. The care is provided in a Medicare-certified skilled nursing facility.
4. The Medicare coverage is for 100 days in a benefit period, with cost-sharing between Medicare and the beneficiary from days 21-100.

Medicare Supplement Insurance ("Medigap")

Since 2010, no new Medigap policies cover an at-home recovery benefit. However, for individuals with older Medigap plans, (D, G, I and J,) their policies may offer coverage, that provides an at-home recovery benefit which pays up to \$40 per visit, up to \$1,600 per year, for personal care services when Medicare covers skilled home health care after an illness or injury. Personal care includes help with activities of daily living, which includes bathing, dressing, eating, toileting and transferring. In order for the Medigap plan to cover any home health care, the beneficiary must first qualify for skilled home health care under Medicare.

Medicaid

Medicaid is the joint federal/state/city funded program that covers all of the health care and long term care needs of persons with low income and limited assets. To qualify for Medicaid as a senior residing at home in the community, the individual must apply and document financial eligibility, along with other criteria. The home health care benefit under Medicaid is available after the treating doctor prescribes the need for skilled and personal care services which can be provided in the individual's home.

CALL 311 AND ASK FOR HIICAP

誰來支付長期護理？

聯邦醫療保險 (Medicare)

聯邦醫療保險對長期護理的承保範圍嚴格限定為「醫療必要」，經醫師認定之狀況。

下列狀況的居家護理由聯邦醫療保險賠付：

1. 所需護理為間歇性專業護理 — 物理治療、職業治療、言語治療、監測病況、更換繃帶、進行注射及檢查器材。「間歇性」的定義是一週少於 7 天，且任何一週不得超過 28 小時。聯邦醫療保險可准予一週提供更多護理時數，但會縮短護理期。一般來說，聯邦醫療保險所核准的護理時數平均為一週 8 至 12 小時。
2. 受益人不能離家，除非是有他人協助或是用輪椅之類輔助。
3. 由醫生決定受益人需要居家護理並開立居家護理治療計畫。
4. 服務是由加盟聯邦醫療保險的認證居家護理機構 (CHHA) 提供。

若符合下列狀況，在專業護理設施所接受的照護可獲聯邦醫療保險賠付：

1. 受益人住院至少 3 天後，於 30 天內至該設施接受照護。
2. 醫生的記錄載明該病患需要專業級的護理；也可以是監護性護理。
3. 護理服務是由聯邦醫療保險認證的專業護理設施提供。
4. 聯邦醫療保險所提供的賠付是權益期內的 100 天，而從第 21 天起至第 100 天，由聯邦醫療保險和受益人分攤費用。

聯邦醫療保險補充保險 ("Medigap")

從 2010 年起，新的醫療保險補充險不再提供居家康復賠付。不過，凡是擁有舊版醫療補充保險計畫 (D、G、I 和 J) 的人士，他們的保單可能會予以承保，當聯邦醫療保險為傷病後的專業居家護理提供賠付時，該計畫的居家康復賠付對個人護理服務支付的每次探訪最高限為 \$40，每年最高限為 \$1,600。個人護理包含協助日常生活的活動，此包括沐浴、更衣、進食、如廁和移動。為了使醫療補充險計畫能對任何居家護理提供賠付，受益人必須先符合資格接受聯邦醫療保險之下的專業居家護理。

醫療補助 (Medicaid)

醫療補助是由聯邦/州/市共同資助的計畫，為低收入和資產有限者提供所有的醫療和長期護理賠付。欲以居住在社區內住宅的老人身份符合醫療補助的資格，必須提出申請並附上文件證明符合財務條件及其他標準。由提供治療的醫生指示需要能在個人住宅提供的專業個人護理服務之後，醫療補助即會給予居家護理賠付。

請致電 311 洽詢 HIICAP

In order for Medicaid to cover the cost of a nursing home stay, the individual must meet the applicable income and resource requirements. Individuals must contribute most of their income to the cost of care, retaining only a modest allowance for personal needs.

Medicaid transfer of asset restrictions: Faced with the prospect of the high costs of long-term care in a nursing home and home care, individuals with accumulated assets sometimes consider a transfer of these assets to family members in order to qualify for Medicaid coverage. A caution: **to be a legitimate transfer**, the senior cannot dictate the family member's use of the funds and the senior, in turn, cannot receive any amount "paid back" from that transfer.

New York State law imposes the following requirements and sanctions if a person transfers assets to become Medicaid-eligible for the purposes of receiving institutional services (note that there is no transfer of asset penalty to receive community Medicaid):

- Transfers to a trust made less than 60 months before you apply for Medicaid will result in a penalty waiting period.
- Medicaid will look at assets transferred 60 months prior to the month of application. If assets were transferred during the applicable lookback period, the applicant will be subject to a penalty period, starting on the date the transfer was made. Medicaid coverage will be refused for the number of months the assets would have paid for care in a nursing home.

Planning Option Eliminates "Surplus Income" for Medicaid Applicants

Disabled individuals of any age with community Medicaid services including home care, adult day care and prescription drug costs can utilize all of their income to pay for living expenses by participating in a **supplemental needs trust**. It is no longer necessary for individuals to contribute their "surplus" or "spenddown" moneys to Medicaid. The pooled-income trust fund, managed by a nonprofit agency, receives the individual's monthly surplus income and redistributes it on behalf of that individual as directed by the individual or their legal representative. Please speak to an eldercare lawyer or a knowledgeable geriatric care manager for further information regarding estate planning and the supplemental needs trust.

為了取得醫療補助對居住在老人院費用的賠付，則必須符合適用的收入和資產條件。個人必須將其大部分收入用於支付護理費用，只保留適當津貼用於個人需要。

醫療補助對資產轉移的限制：面對未來在老人院及居家護理的高額長期護理費用，累積相當資產者有時會考慮把資產轉移給家人，以便能符合醫療補助賠付的資格。請注意：**須為合法轉移**，老人不得指揮家人對資金的用途，而且老人也不能從轉移中收取任何金額的「回扣」。

若轉移資產以符合醫療補助的資格是為了能接受機構式的照護服務，紐約州法令採行下列規定與處罰措施 (請注意接受社區型醫療補助並不會有轉移資產的懲罰)：

- 轉移至信託的時間若是距離申請醫療補助不到 60 個月，將會有懲罰性的等候期。
- 醫療補助計畫將會審查提出申請該月之前 60 個月所轉移的資產。若資產轉移是發生於適用的回顧期內，申請人將面臨懲罰期，從進行轉移之日開始起算。對於資產應用於支付老人院護理費用的月數，醫療補助將拒絕賠付。

醫療補助申請人排除「收入盈餘」的規劃選項

殘障者不論年齡，只要是接受社區型醫療補助服務，包括：居家護理、成人日間照護和處方藥費用，經由參加**補助需求信託**，就可以把他們的全部收入用於支付生活支出。再也不必把他們的「盈餘」貢獻給醫療補助，或是為了醫療補助而「消耗」其收入。此一集合式收入信託基金是由非營利機構管理，在收到個人的每月收入盈餘之後，會根據其本人或法律代表的指示為其進行重分配。請洽詢專精老年護理規劃的律師或學識豐富的老人護理管理人員，以進一步瞭解關於資產規劃和補助需求信託的資訊。

Community Spouse Protection: When a husband or wife enters a long-term care facility, the spouse remaining at home is protected from financial impoverishment due to covering the costs of care. Federal and New York State law mandate that the community spouse be allowed to retain the couple's home, car, personal belongings and a sum of money from their joint assets. In 2016 under Medicaid, the community spouse may retain a minimum of \$74,820 and a maximum of \$119,220 in assets and \$2,980.50 per month in income. However, when both spouses are in a home care situation, the Community Spouse Protection does not apply. When one or both spouses are receiving care at home under the Medicaid program, they are allowed to keep income and resources only at the Medicaid-eligible levels shown on page 40.

By law, states are required to impose estate recovery, which is a claim against the estate of the deceased person, including their home, for what Medicaid paid for the person's at-home or nursing home care. The claim process cannot begin until after the death of the surviving spouse or surviving minor child.

共同生活之配偶保障：當夫妻一方進入長期護理設施後，留在家中的配偶因須支付護理費用而受到財務保障。聯邦和紐約州法律規定，共同生活之配偶准予保有兩人的住宅、車輛、個人物品和共同資產中的一些款項。根據醫療補助計畫在 2016 年的規定，共同生活之配偶得以保有 \$74,820 以上、\$119,220 以下之資產，以及每月 \$2,980.50 的收入。然而，當夫妻兩人都處於居家護理的狀態時，共同生活之配偶保障便不適用。當夫妻中之一人或兩人在醫療補助計畫之下接受居家護理時，他們只能保有合乎醫療補助資格水準 (請見第 40 頁) 的收入與資產。

依照法律，各州必須採行遺產收復措施，此為主張擁有去世者包括其住宅之資產的權利，以抵付醫療補助計畫為其所支付的居家或老人院護理。此項主張權利的程序在其配偶或未成年子女在世時不得展開。

LONG TERM CARE INSURANCE

Long term care insurance (LTCI) pays for all or some expenses related to long term care, including care needed at home, in a nursing home, in a community based setting, and assisted living facilities. Individuals purchase policies to protect income and resources, as well as to maintain independence, financial control, and expand care options.

The Basics of LTCI

The process for selecting a LTCI policy is complex, and the policy might not even pay for all of the costs of long term care. However, in the event that you need long term care for many months or years, and don't have sufficient funds or an insurance policy to pay for the care, the costs may be catastrophic for you and your family. Buying a long-term care insurance policy assures at least partial coverage for nursing home, home care and other types of care. If the costs of long term care require all of your income and assets, then you would eventually qualify for Medicaid.

Unlike medical insurance, the LTCI company must **"health qualify"** you for insurance, so they will ask a series of health questions and/or perform a physical before qualifying you for coverage. They have the right to deny coverage. Therefore, if you want to buy the insurance because you need the benefits today, you'll have a hard time getting covered. LTCI is something to purchase when you are in relatively good health.

How would I purchase a policy? Can I afford it?

LTCI is bought through insurance agents (who represent one company), insurance brokers (who represent multiple companies), or some employer benefits have a long term care insurance policy you can purchase. Each insurance company sets its own rates. When comparing nearly identical policies, the rates can vary. Rates also vary according to where you live. If you have two residences, it may be worth reviewing costs in both locations. The average price for a comprehensive long term care insurance policy for someone over 60 years in relatively good health is about \$5,000 per year. However, the average cost of care in NYC is \$360 per day which is much higher than the national average at \$229 per day, so your cost may be significantly different.

LTCI policies are structured with a daily amount (for example, \$200 per day) of nursing home and home care for a period of time (for example, 3 years). Keep in mind that if your policy has a daily amount of \$200 per day and the cost of care is \$360, then you would be responsible for the difference (\$160 per day) even though you had a LTCI policy. However, there are insurance riders, inflation protection, and many other options that change the cost and level of care covered under the policy.

Policies have many coverage options, so it is important to think through what you feel you can afford and what you ultimately want the policy to pay for. Each option increases or decreases the cost of the premium. In general, if a premium is more than 8% of your net income, then the policy may be too expensive for you.

CALL 311 AND ASK FOR HIICAP

長期護理保險

長期護理保險 (LTCI) 支付與長期護理相關之部分或全部費用，包括：居家所需的照護、在老人院、社區型環境內的照護及生活輔助設施。購買此類保單可用以保護個人收入與資產，並能維持獨立性、對財務的控制及擴大護理服務的選項。

長期護理保險基本須知

挑選長期護理保險的過程是複雜的，而且保單甚至可能不會賠付所有的長期護理費用。然而，如果需要多個月或多年的長期護理，又沒有足夠的資金或保險來支付護理費用，對於自己和家人都可能是一場災難。購買長期護理保險能保證對老人院、居家護理及其他型態的護理至少提供部分賠付。如果長期護理費用需要動用全部收入和資產來支應，最終可能有資格申請醫療補助。

和醫療保險不同，長期護理保險公司必須確定「**健康合格**」才提供保險，所以他們會詢問一系列健康問題並／或進行身體檢查之後，才能確定您符合保險資格。他們有權拒保。因此，若是因為現在即刻需要保險福利而想要購買保險，將會很難得到承保。長期護理保險是在健康狀況相當良好時購買的保險。

如何購買保單？我能負擔得起嗎？

可透過保險代理（代表一家公司）或保險經紀（代表多家公司）購買長期護理保險，或是有些雇主的保險福利有長期護理保險保單可供購買。各家保險公司自訂費率。以幾乎一模一樣的保單相比較，費率也不盡相同。費率也會因居住地而有差異。若有兩個居住地點，不妨查看比較兩處的費用。年齡在 60 歲以上且健康狀況相當良好者的綜合長期護理保險保單平均價格為每年 \$5,000。然而，紐約市的護理費用為平均每天 \$360，遠高於每天 \$229 的全國平均費用，所以您的費用可能會有顯著差異。

長期護理保險保單是以老人院的每日金額（例如：每天 \$200）和居家護理的時間期（例如：3 年）構成。請記得，如果保單的每日金額為 \$200，而護理費用為 \$360，則即使您擁有長期護理保險保單，仍須負責支付差額（每天 \$160）。不過，附加保險、通膨保護及許多其他選項會改變費用和保單賠付的護理等級。

保單有多種承保範圍選項，因此審慎思考自己的負擔能力和最終希望保險賠付的項目很重要。每一選項都會使保費成本有所增減。一般來說，如果保費超過淨收入的 8%，則該份保單對您而言可能太貴了。

請致電 311 洽詢 HIICAP

Will my premium increase after I own a policy?

In recent years, insurance companies have raised the premiums on policies. Rate increases are regulated by New York State and are not increased according to the policy holder's health. Instead, companies may raise all rates of policy holders who purchased policies in a specific year (for example, 2001) by 20%. If you are a current policy holder with rates that have been increased and feel that the new premium is too expensive, contact the insurance company directly. They can work to change the benefits to make the policy more affordable. If you stop paying your premiums, then you lose your policy and the previous premium payments made.

Opinions vary greatly on the need and utility of purchasing a LTCI policy. You could pay the premiums for many years without receiving benefits. In addition, the benefits and funds are not transferrable to others.

Types of Long Term Care Insurance Policies in New York State

There are two types of long term care insurance policies that you can purchase in New York.

1. **Traditional, non-partnership private insurance policies** offer flexibility and customization of options for long term care benefits with a wide range of price points. When the benefit is finished, if care is still needed, then the individual has to use his/her own resources to cover care expenses (or apply for Medicaid and be subject to Medicaid's income and resource guidelines).
2. **The New York State Partnership for Long-Term Care** program combines private long term care insurance with Medicaid Extended Coverage. After exhausting the benefits of a private long term care insurance policy, the individual would then qualify for Extended Medicaid Coverage without having to "spend down" resources to qualify for Medicaid. This provision allows the Partnership policyholder to have a lifetime benefit of long term care coverage without having to spend down all one's resources to qualify for Medicaid; one's own income must be used first before Medicaid pays for services.

To utilize Medicaid Extended Coverage benefits, the beneficiary must reside in New York State or in a state that offers reciprocity. The majority of states with partnership policies offer reciprocity for policy holders. However, partnership policy holders are subject to the LTC Medicaid benefits offered in the state they are residing at the time of using the coverage. For example, if you bought a NYS Partnership policy and are residing in Florida at the time of triggering the benefits, then your policy will be honored. However, the benefits of the Medicaid Extended Coverage will be subject to the benefits offered by Florida, not New York. Reciprocity with other States offers more flexibility, but the benefits for the Medicaid extended coverage may vary a bit.

More information about New York State Partnership policies can be obtained by calling the Consumer Hotline of the **NYS Partnership for Long-Term Care** at 1-866-950-7526 or visiting www.nyspltc.org.

持有保單後，保費會不會增加？

最近幾年保險公司已經提高保單的保費。費率調漲受到紐約州監管，並不是根據保單持有人的健康狀況來調整。而是保險公司可能會將某一特定年份（例如：2001 年）購買保單之所有保單持有人的費率全部調漲 20%。若您目前是保單持有人且因保費上漲而覺得新保費太貴，請直接聯絡保險公司。他們可以設法變更保險福利，以使保單較易負擔。若您停止支付保費，便會喪失保單及以前所付的保費。

對於購買長期護理保險保單的需求和用途，各方看法分歧。可能支付保費多年卻未獲得賠付。而且，賠付和款項不得轉讓他人。

紐約州長期護理保險保單的種類

在紐約州有兩種類型的長期護理保險保單可供購買。

1. **傳統、非合作型私營保險保單**為長期護理所提供的賠付具有彈性，且可依照個人喜好作設定，還有許多不同價位可供選擇。當賠付終止時，若仍需要照護，則必須動用自己的資源來支應照護費用。（或申請醫療補助，須受醫療補助的收入和資產規定約束）。
2. **紐約州長期護理合作計畫**結合私營長期護理保險和「醫療補助擴大賠付範圍」。在私營長期護理保險保單的賠付用罄之後，即符合「醫療補助擴大賠付範圍」的資格，而不必「消耗」資產以符合醫療補助的資格。此項規定讓合作型保單持有人能終身享有長期護理賠付，而無須消耗其全部資產以求符合醫療補助的資格；在醫療補助為服務提供賠付之前，必須先以其自有收入先行支付。欲利用「醫療補助擴大賠付範圍」的賠付，受益人必須居住在紐約州或是提供互惠措施的州。大多數擁有合作型保單的州都對保單持有人提供互惠措施。不過，在使用保險賠付時，合作型保單持有人須受其所居住州提供之長期護理醫療補助賠付的約束。例如：若購買了紐約州合作型保單，而在動用賠付時是居住在佛羅里達州，該保單將會受理。不過，醫療補助擴大賠付範圍的賠付將受到佛羅里達州所提供賠付的約束，而非紐約州的。與他州的互惠措施提供更大的靈活性，但醫療補助擴大賠付範圍的賠付可能稍有不同。

欲取得關於紐約州合作型保單的更多資訊，請致電 **1-866-950-7526** 紐約州長期護理合作計畫消費者熱線或造訪 www.nyspltc.org。

There are many Long Term Care Insurance terms. Below are some of the common terms.

Long-Term Care Insurance: Definitions

Benefit Trigger: Benefits triggers is the term used by insurance companies to describe the criteria and methods they use to determine when you are eligible to receive benefits. All policies in New York State are based on the policy-holder's inability to carry out a certain number of "activities of daily living" and/or "cognitive impairment." Carefully review how each insurer determines your eligibility, and how the policy defines the benefit triggers.

Daily Benefit: Insurance policies generally pay a fixed dollar amount per day. The Daily Benefit refers to how much your policy will pay per day. For example, an individual may select a policy that pays a daily benefit of \$200 for nursing home coverage. Insurance companies assign a percentage that the policy will pay for home care services, usually between 50-100% of what the policy will pay for nursing home care. If receiving care at home is important to you, then research the policy's coverage for home care.

Costs differ within the nation and within the state, so researching the average cost of care in your area is an important factor to consider. For more information about average nursing home costs in New York, visit www.health.state.ny.us/facilities/nursing/estimated_average_rates.htm.

Elimination Period: The elimination period, or sometimes called waiting period, is a type of deductible. It is the period of time (usually 90 days) during which you need long-term care services, but before the policy benefits begin. You pay for 100% of the cost of services during this period. Therefore, policy holders will need to have liquid assets available to pay for services during the elimination period.

Inflation Protection: Inflation protection provides protection against the increases in long term care services over time. Inflation protection is incorporated into the policy's premium, and benefits continue to increase throughout the life of the policy. Purchasing a policy with inflation protection is especially important if you purchase a policy when you are younger.

Length of the Benefit: The number of years (usually 3 years) a policy will cover your long term care needs, beginning at the end of the elimination period. For example, if you begin to use the policy's benefits when you are 70 years old, a 3 year policy will provide the benefits of your policy until you are 73 years old.

Pre-Existing Condition Period: This limits the payment of benefits due to a condition that existed on the effective date of the coverage. The limit can only apply to conditions for which medical advice or treatment was recommended or received from a health professional within the six month period before the effective date of coverage. When you apply for coverage, it is important to disclose all of your medical information truthfully.

長期護理保險有許多專用術語，以下是一些常用術語。

長期護理保險：定義

賠付條件：賠付條件是保險公司用以說明他們用來決定何時有資格領取賠付之標準及方法的術語。紐約州的所有保單都是以保單持有人無能力進行某些日常生活的活動和/或「認知能力障礙」為基礎。仔細查看每家保險公司如何判定資格，以及保單是如何界定賠付條件。

每日賠付：保單一般每天賠付固定金額。每日賠付是指保單將會每天賠付多少金額。例如：某人可能選擇的保單是每日賠付 \$200，以支應老人院的費用。保險公司會分配保單對居家護理服務賠付的百分比，通常介於保單對老人院照護賠付的 50% 至 100% 之間。如果接受居家護理對您很重要，即須研究保單對居家護理的承保範圍。

在國內和在州內的費用都會有差異，因此對您所在地區的平均照護成本進行研究是很重要的考慮因素。欲進一步瞭解紐約老人院的平均費用，請至 www.health.state.ny.us/facilities/nursing/estimated_average_rates.htm。

免責期：免責期（或有時稱為等候期）是一種類型的自付額。這一段時間（一般是 90 天）需要長期護理服務，但是保單的賠付尚未開始。您須支付這段期間 100% 的服務費用。因此，保單持有人需要有流動資產可供支付免責期期間的服務。

通膨保護：通膨保護是對與日俱增的長期護理服務提供的保障。通膨保護是併入保單的保費之中，在保單有效期內賠付會持續增加。若是在年輕時購買保單，購買附有通膨保護的保單尤其重要。

賠付期：保單承保您的長期護理需求的年限（一般為 3 年），從免責期結束時開始。例如，若您在 70 歲時開始使用該保單的賠付，3 年保單將提供保單賠付至您 73 歲時止。

帶病投保期：由於在保險計畫生效前即已患有的疾病，而使得保險賠付受到限制。此項設限僅適用於在保險計畫生效前之六個月期間內，由醫療專業人員提出醫藥或治療建議或進行治療的疾病。在申請保險計畫時，誠實告知全部醫療資訊是很重要的。

Tax Deductions for Long-Term Care Premiums can be made for policies that are listed as tax qualified. A federal tax deduction for long term care insurance is claimed as an itemized medical expense that must exceed 7.5% of your adjusted gross income. Since these premiums can be costly, especially for seniors, it is intended as an incentive for purchasing coverage. In 2016, taxpayers can deduct the cost of the policy's premium, up to the maximum, by age:

Taxpayer age 40 years and under	\$390
Taxpayer age 41-50 years	\$730
Taxpayer age 51-60 years	\$1,460
Taxpayer age 61-70 years	\$3,900
Taxpayer 71 years or older	\$4,870

A New York State Tax Deduction can be claimed as an above the line tax credits of 20% of the premiums using the IT-249 tax form. Tax form IT-249 can be found at http://www.tax.ny.gov/pdf/current_forms/it/it249_fill_in.pdf. Instructions can be found at http://www.tax.ny.gov/pdf/current_forms/it/it249i.pdf.

More information on long term care insurance can be found at the New York State Insurance website: http://www.dfs.ny.gov/consumer/ltc/ltc_index.htm.

長期護理保費用做稅務扣除額是可以的，條件是保單需符合稅務資格。報稅時需要將長期護理保險列為醫療支出作申報，支出必須超過調整後總收入的 7.5%，才能作為聯邦稅扣除額。由於這些保費可能相當昂貴，尤其是對老年人而言，因此這是購買保險的一項誘因。在 2014 年，納稅人可以扣除的保費支出依年齡而定的最高限如下：

納稅人年齡為 40 歲 (含) 以下	\$390
納稅人年齡為 41-50 歲	\$730
納稅人年齡為 51-60 歲	\$1,460
納稅人年齡為 61-70 歲	\$3,900
納稅人年齡為 71 歲 (含) 以上	\$4,870

申報紐約州稅扣除額時可以使用 IT-249 報稅表，將 20% 保費列為經常項目。IT-249 報稅表可在下列網址取得：http://www.tax.ny.gov/pdf/current_forms/it/it249_fill_in.pdf。填表說明可在下列網址查閱：http://www.tax.ny.gov/pdf/current_forms/it/it249i.pdf。

關於長期護理保險的詳情，可瀏覽紐約州保險網站：http://www.dfs.ny.gov/consumer/ltc/ltc_index.htm。

MEDICARE 2016

ORIGINAL MEDICARE DEDUCTIBLES, CO-INSURANCE & PREMIUM AMOUNTS

Part A: Hospital Insurance

Deductible	\$1,288 per benefit period
Co-Payment	\$322 per day for days 61-90 of each benefit period \$644 per day for each "lifetime reserve day"
Skilled Nursing Facility Co-Pay	\$161 per day for days 21-100 of each benefit period

Part B: Medical Insurance

Monthly Premium	Most Medicare beneficiaries will continue to pay the 2015 monthly premium rate of \$104.90 . The following beneficiaries will pay \$121.80/month : <ul style="list-style-type: none"> Those who first enroll in Part B in 2016; and Those who are not yet collecting Social Security benefits, even though they may have had Part B in 2015.
Annual Deductible	\$166
Co-Insurance	20% for most services

Some people 65 or older do not meet the SSA requirements for **premium-free Hospital Insurance (Part A)**. If you are in this category, you can get Part A by paying a monthly premium. This is called "premium hospital insurance." In 2016, if you have less than 30 quarters of Social Security coverage, your Part A premium will be \$411 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium will be \$226 per month.

Medicare Savings Programs for Low-Income Medicare Beneficiaries (2016)

	Monthly Income Limit (after any deductions/exclusions)	
	Individual	Couple
QMB - Qualified Medicare Beneficiary NY State pays premiums, deductibles and co-insurance for those who are automatically eligible for Part A.	\$990*	\$1,335
SLMB - Specified Low-Income Medicare Beneficiary Levels State pays Medicare Part B premium only.	\$1,188	\$1,602
QI - Qualifying Individuals State pays Medicare Part B premium only.	\$1,337	\$1,802

*You can also apply for QMB if you earn less than the above ranges but are not interested in applying for Medicaid.

CALL 311 AND ASK FOR HIICAP

2016 年聯邦醫療保險

聯邦醫療保險原始計畫自付額、共保額及保費金額 A 部分：住院保險

自付額	\$1,288 (每一段權益期)
共付額	每一段權益期的第 61 天至 90 天為每日支付 \$322 每一段「終身儲備期」為每日 \$644
專業護理設施共付額	每段權益期的第 21 天至 100 天為每日支付 \$161

B 部分：醫療保險

月保費	大部分聯邦醫療保險受益人將繼續支付 2015 年的月保費 \$104.90 。 以下受益人將支付 \$121.80/月 ： <ul style="list-style-type: none"> 2016 年第一次加入 B 部分的人；以及 即便在 2015 年加入聯邦醫療保險 B 部分但未領取社會安全福利金的人
年度自付額	\$166
共保額	大部分服務為 20%

有些 65 歲 (含) 以上人士因不符合社會安全局的條件而無免保費住院保險 (A 部分)。屬於此一類者，可支付月保費以取得 A 部分。此稱之為「保費型住院保險」。2016 年，若您擁有社會安全保險少於 30 個工作季點，A 部分保費將是每月 \$411。若您的社會安全保險累積了 30 至 39 個工作季點，A 部分保費將是每月 \$226。

聯邦醫療保險免保費計畫 低收入聯邦醫療保險受益人 (2016年)

	月收入限制 (減去任何扣除額/抵免之後)	
	個人	夫妻
QMB — 合格聯邦醫療保險受益人計畫 紐約州為自動符合 A 部分保險計畫資格者支付保費、自付額和共保額。	\$990*	\$1,335
SLMB — 特定低收入聯邦醫療保險受益人等級 紐約州僅支付聯邦醫療保險 B 部分保費。	\$1,188	\$1,602
QI — 合格個人計畫 紐約州僅支付聯邦醫療保險 B 部分保費。	\$1,337	\$1,802

*如果您的所得低於上述範圍，但是無意申請醫療補助，也可以申請 QMB。

請致電 311 洽詢 HIICAP

MEDICAID 2016

Standard Medicaid

Maximum Income and Asset Levels* for those who are blind, disabled or age 65 and over:

	<u>Monthly Income</u>	<u>Assets</u>
Individual	\$825	\$14,850
Couple	\$1,209	\$21,750

*The first \$20 of income is exempt. Above figures are prior to the \$20 disregard. You are permitted a burial fund allowance of \$1,500 per person.

Nursing Home-Based Medicaid

INCOME: When a nursing home resident qualifies for Medicaid support, all income goes to the nursing home except for \$50 monthly allowance for the resident's personal needs.

ASSETS: All personal assets must be used up first to meet costs (excluding: primary residence, automobile and personal possessions).

MARRIED COUPLES: When one spouse in a married couple qualifies for Medicaid support in a nursing home, the community spouse (the one remaining at home) is entitled to retain some income and resources belonging to the couple while Medicaid pays towards the residential spousal care.

The community spouse is allowed to retain the following:

Resources: \$74,820 minimum; \$119,220 maximum **Income:** \$2,980.50 monthly

For more information on Medicaid, call HRA's Medicaid Helpline at 1-888-692-6116.

醫療補助 2016

標準醫療補助

失明、殘障或 65 歲 (含) 以上者的收入與資產最高限*：

	<u>月收入</u>	<u>資產</u>
個人	\$825	\$14,850
夫妻	\$1,209	\$21,750

*收入的首 \$20 可豁免。以上數字尚未扣除 \$20。准予擁有的葬儀金津貼為每人 \$1,500。

住在老人院的醫療補助

收入：住在老人院的人士符合領取醫療補助的補貼資格時，除了每個月 \$50 的津貼留做其個人需要之用，所有的收入都歸老人院所有。

資產：所有的個人資產都必須先用以支付費用（不包括：主要住宅、汽車和個人物品）。

已婚夫妻：已婚夫妻中之一人符合醫療補助對老人院的補貼時，其配偶（仍居住在家中者）可以保留部分收入和兩人共有之資產，而醫療補助支付接受住宿照護的配偶。

共同生活之配偶得以保有：

資產：\$74,820 以上；\$119,220 以下

收入：每月 \$2,980.50

欲進一步瞭解醫療補助，請致電人力資源管理局 (HRA) 的醫療補助專線 1-888-692-6116。

**Medicare Part B Premium and Part D Surcharge Chart
for Higher Income Medicare Beneficiaries**

**針對高收入聯邦醫療保險受益人的
聯邦醫療保險 B 部分保費和 D 部分附加費率表**

Modified Adjusted Gross Income (MAGI)	Part B Monthly Premium	Part D (Prescription Drug) Monthly Premium
Individuals with a MAGI of \$85,000 or less / Married couples with a MAGI of \$170,000 or less	2016 Standard Premium = \$121	Your Plan Premium
Individuals with a MAGI above \$85,000 up to \$107,000/ Married couples with a MAGI above \$170,000 up to \$214,000	\$170.50	Your Plan Premium + \$12.70
Individuals with a MAGI above \$107,000 up to \$160,000/ Married couples with a MAGI above \$214,000 up to \$320,000	\$243.60	Your Plan Premium + \$32.80
Individuals with a MAGI above \$160,000 up to \$214,000/ Married couples with a MAGI above \$320,000 up to \$428,000	\$316.70	Your Plan Premium + \$52.80
Individuals with a MAGI above \$214,000/ Married couples with a MAGI above \$428,000	\$389.80	Your Plan Premium + \$72.90

修正調整後年總收入 (MAGI)	B 部分月保費	D 部分 (處方藥) 月保費
個人 MAGI 為 \$85,000 或以下/ 已婚夫妻 MAGI 為 \$170,000 或以下	2016 標準保費 = \$121	您的保費
個人 MAGI 超過 \$85,000 至 \$107,000/ 已婚夫妻 MAGI 超過 \$170,000 至 \$214,000	\$170.50	您的保費 + \$12.70
個人 MAGI 超過 \$107,000 至 \$160,000/ 已婚夫妻 MAGI 超過 \$214,000 至 \$320,000	\$243.60	您的保費 + \$32.80
個人 MAGI 超過 \$160,000 至 \$214,000/ 已婚夫妻 MAGI 超過 \$320,000 至 \$428,000	\$316.70	您的保費 + \$52.80
個人 MAGI 超過 \$214,000/ 已婚夫妻 MAGI 超過 \$428,000	\$389.80	您的保費 + \$72.90

For more information visit the Social Security Administration's website at www.ssa.gov.

欲取得更多資訊，請造訪社會安全局網站：www.ssa.gov。

RESOURCES

NYC HIICAP Helpline..... http://www.nyc.gov/html/dfta/html/benefits/health.shtml	311 – ask for HIICAP
Department for the Aging..... www.nyc.gov/aging	311
Access-A-Ride..... http://web.mta.info/nyct/paratran/guide.htm	1-877-337-2017
Advocacy, Counseling and Entitlement Services Project (ACES).....	1-212-614-5552
Attorney General Bureau of Consumer Fraud and Protection..... www.ag.ny.gov	1-800-771-7755
BigAppleRx Discount Card..... www.BigAppleRx.com	1-888-454-5602 TTY:1-800-662-1220
Center for the Independence of the Disabled in New York..... www.cidny.org	1-212-674-2300
Centers for Medicare and Medicaid Services (CMS)..... www.cms.gov	1-800-MEDICARE
Community Health Advocates..... www.communityhealthadvocates.org	1-888-614-5400
Eldercare Locator..... www.eldercare.gov	1-800-677-1116
Elderly Pharmaceutical Insurance Coverage (EPIC)..... www.health.state.ny.us/health_care/epic/index.htm	1-800-332-3742
HEAR NOW (provides hearing aids to people with limited resources).... www.sotheworldmayhear.org/hearnow/	1-800-328-8602
Health Information Tool for Empowerment (resource directory of free and low cost health and social services)..... www.HiteSite.org	1-866-370-4483
Health and Hospitals Corporation (HHC Options)..... www.nychhc.org/hhc/html/patients/ForPatients-PayingOptions.shtml	311
HRA Info Line – for all HRA programs, including Food Stamps, Public Assistance and Medicaid.....	1-718-557-1399
Hospice Foundation of America..... www.hospicefoundation.org	1-800-854-3402
Independent Consumer Advocacy Network (ICAN) – Medicaid managed long term care ombudsman.....	1-844-614-8800
LawHelp.org (to search for legal services, including pro bono) Legal Services NYC..... www.lsnyc.org	1-917-661-4500
Limited Income Newly Eligible Transition (LINET) Program.....	1-800-783-1307
Livanta, LLC - (Quality Improvement Organization to appeal hospital discharge and make quality of care complaints).....	1-866-815-5440
Medicaid referral for providers accepting Medicaid.....	1-800-541-2831
Medicare Fraud Hotline (Office of the Inspector General, DHHS).....	1-800-447-8477
Medicare Hotline.....	1-800-MEDICARE

CALL 311 AND ASK FOR HIICAP

資源

紐約市 HIICAP 熱線..... http://www.nyc.gov/html/dfta/html/benefits/health.shtml	311 — 洽詢 HIICAP
老人局..... www.nyc.gov/aging	311
Access-A-Ride 殘障專車..... http://web.mta.info/nyct/paratran/guide.htm	1-877-337-2017
宣導、諮商與權益服務方案 (ACES).....	1-212-614-5552
檢察長辦公廳消費者保護局..... www.ag.ny.gov	1-800-771-7755
BigAppleRx 折扣卡..... www.BigAppleRx.com	1-888-454-5602 聽障專線：1-800-662-1220
紐約身心障礙人士獨立中心..... www.cidny.org	1-212-674-2300
聯邦醫療保險和醫療補助服務中心 (CMS)..... www.cms.gov	1-800-MEDICARE
社區健康維護者..... www.communityhealthadvocates.org	1-888-614-5400
老年保健指南..... www.eldercare.gov	1-800-677-1116
老人藥品保險 (EPIC)..... www.health.state.ny.us/health_care/epic/index.htm	1-800-332-3742
HEAR NOW (為資產有限人士提供助聽器)..... www.sotheworldmayhear.org/hearnow/	1-800-328-8602
自主能力健康資訊工具（免費及低收費保健和社會服務資源目錄）..... HiteSite.org	1-866-370-4483
健康及醫院總局 (HHC Options)..... www.nychhc.org/hhc/html/patients/ForPatients-PayingOptions.shtml	311
人力資源管理局 (HRA) 資訊專線 提供所有 HRA 計畫的資訊，包括食物券、公共援助和醫療補助.....	1-718-557-1399
美國安寧療護基金會..... www.hospicefoundation.org	1-800-854-3402
独立消费者维权网 (ICAN) — 医疗补助管理式长期护理监察.....	1-844-614-8800
LawHelp.org (搜尋法律服務，包括無償服務) 紐約市法律服務 (Legal Services NYC)..... www.lsnyc.org	1-917-661-4500
收入有限人士新增資格過渡 (LINET) 計畫	1-800-783-1307
Livanta, LLC — (品質改善組織，進行出院申訴及護理品質投訴).....	1-866-815-5440
聯邦醫療保險轉介接受醫療補助的醫療業者.....	1-800-541-2831
聯邦醫療保險詐騙熱線 (稽核長辦公室，DHHS).....	1-800-447-8477
聯邦醫療保險熱線.....	1-800-MEDICARE

請致電 311 洽詢 HIICAP

Medicare Rights Center.....	1-800-333-4114
www.medicarerights.org	
National Council on Aging: www.ncoa.org	
National Health Information Center: www.health.gov/nhic	
New York State of Health (Marketplace Plan contact).....	1-855-355-5777
https://nystateofhealth.ny.gov	
NYC Department of Health.....	311
www.nyc.gov/health	
NYC Long Term Care Ombudsman Program.....	1-212-962-7559
www.nyfsc.org/services/ombuds.html	
NYS Department of Health-HMO complaints.....	1-800-206-8125
NYS Department of Financial Services.....	1-800-342-3736
www.dfs.ny.gov	
NYS Medicaid Helpline.....	1-800-541-2831
www.nyhealth.gov/health_care/medicaid	
NYS Office for the Aging Senior Citizen Helpline.....	1-800-342-9871
www.aging.ny.gov	
NYS Office of Crime Victim Services.....	1-800-247-8035
www.ovs.ny.gov/helpforcrimevictims.html	
NYS Office of Professional Medical Conduct (physician quality control complaints).....	1-800-663-6114
NYU Dental Clinic.....	1-800-998-9800
www.nyu.edu/dental	
Railroad Retirement Board.....	1-877-772-5772
www.rrb.gov	
SMP (formerly Senior Medicare Patrol) in NYS.....	1-877-678-4697
Social Security Administration.....	1-800-772-1213
www.socialsecurity.gov	
United States Department of Veterans Affairs.....	1-800-827-1000
www.va.gov	

聯邦醫療保險權益中心.....	1-800-333-4114
www.medicarerights.org	
美國老年人理事會: www.ncoa.org	
國家健康資訊中心: www.health.gov/nhic	
紐約州健康部 (健保市場計畫聯絡人)	1-855-355-5777
https://nystateofhealth.ny.gov	
紐約市衛生局.....	311
www.nyc.gov/health	
紐約市長期護理調解員計畫.....	1-212-962-7559
www.nyfsc.org/services/ombuds.html	
紐約州衛生署 HMO 投訴.....	1-800-206-8125
紐約州金融服務廳.....	1-800-342-3736
www.dfs.ny.gov	
紐約州醫療補助專線.....	1-800-541-2831
www.nyhealth.gov/health_care/medicaid	
紐約州老人局老人服務專線.....	1-800-342-9871
www.aging.ny.gov	
紐約州犯罪受害者服務辦公室.....	1-800-247-8035
www.ovs.ny.gov/helpforcrimevictims.html	
紐約州專業醫療行為辦公室 (醫療品質管理投訴).....	1-800-663-6114
紐約大學牙醫診所.....	1-800-998-9800
www.nyu.edu/dental	
鐵路職工退休管理委員會.....	1-877-772-5772
www.rrb.gov	
紐約州 SMP (原老人醫療保險巡邏計畫)	1-877-678-4697
社會安全局.....	1-800-772-1213
www.socialsecurity.gov	
美國退伍軍人事務部.....	1-800-827-1000
www.va.gov	

CALL 311 AND ASK FOR HIICAP

請致電 311 洽詢 HIICAP

Resources for Assistance Paying for Prescription Medications
(Each program can have their own eligibility requirements. Please call or check the website for additional qualifying information and how to apply.)

Benefits Check Up – Helps people locate benefits and services available to them. www.benefitscheckup.org

CancerCare Co-Payment Assistance Foundation – Helps eligible individuals with co-payment assistance for chemotherapy and targeted treatment drugs. www.cancercarecopay.org or 1-866-552-6729.

Caring Voice Coalition – May be able to help pay for the cost of some prescriptions for people with certain chronic conditions. Visit www.caringvoice.org or call 1-888-267-1440 for more information.

Good Days (formerly Chronic Disease Fund) – Helps people with certain chronic diseases to pay their insurance copays. For more information, and a list of qualifying diseases and medications, visit GoodDaysfromCDF.org or call 1-972-608-7141.

HealthWell Foundation - Provides financial assistance to eligible individuals to cover coinsurance, copayments, health care premiums and deductibles for certain medications and therapies. Healthwellfoundation.org or 1-800-675-8416

Leukemia and Lymphoma Society Co-Pay Assistance Program – Helps pay for insurance premiums (both private and Medicare-related premiums) and copays. <https://www.lls.org/support/information-specialists> or 1-800-955-4572

National Association of Boards of Pharmacies (NABP) – Allows you to search for internet pharmacies that are certified as safe distributors. www.nabp.net

National Marrow Patient Assistance Program and Financial Assistance Fund – May assist eligible individuals with the cost of bone marrow or cord blood transplant if insurance does not cover the full cost. www.bethematch.org or 1-888-999-6743

National Organization for Rare Diseases (NORD) – Helps uninsured or underinsured individuals with certain health conditions to access needed medications. www.rarediseases.org or 1-800-999-6673

NeedyMeds.com – Provides information on medications and patient programs explaining how to apply to each one. www.needymeds.com

Partnership for Prescription Assistance - Helps people access free or low-cost prescription medications. Also provides links for programs that assist with paying co- payments. www.pparx.org or 1-888-4PPA-NOW

Patient Advocate Foundation Co-Pay Relief Program – Helps eligible individuals with certain diagnoses to pay copayments for prescription medications. www.copays.org or 1-866-512-3861, Option 1.

CALL 311 AND ASK FOR HIICAP

援助支付處方藥的資源
(每項計畫均有自身的資格要求。如欲獲取更多資格要求資訊以及瞭解如何申請，請撥打電話或查看網址。)

福利查詢 (Benefits Check Up) — 協助找尋適用的福利和服務。 www.benefitscheckup.org

癌症護理共付額援助基金 (CancerCare Co-Payment Assistance Foundation) — 為有資格條件的人提供共付額援助，以便進行化療和獲取靶向治療藥物。造訪 www.cancercarecopay.org 或撥打 1-866-552-6729。

關愛之聲聯盟 (Caring Voice Coalition) — 可幫助患有慢性疾病的人支付一些處方藥的費用。造訪 www.caringvoice.org 或致電 1-888-267-1440 獲取更多資訊。

好日子 (Good Days) (原慢性疾病基金) — 幫助某些患有慢性疾病的人支付保險共付額。如欲獲取更多資訊以及符合條件的疾病和藥物名稱列表，請造訪 GoodDaysfromCDF.org 或致電 1-972-608-7141。

健康基金會 (HealthWell Foundation) — 為符合條件的人提供經濟援助以支付某些藥物和治療的共保額、共付額、健康保險和自付額。造訪 Healthwellfoundation.org 或致電 1-800-675-8416

白血病和淋巴瘤學會共付額援助計畫 (Leukemia and Lymphoma Society Co-Pay Assistance Program) — 幫助支付保費（私人或聯邦醫療保險相關保費均可）和共付額。造訪 <https://www.lls.org/support/information-specialists> 或致電 1-800-955-4572

美國藥事局全國聯合會 (NABP) — 可搜尋經認證為安全經銷商的網上藥房。 www.nabp.net

國家骨髓病患者援助計畫與經濟援助基金 (National Marrow Patient Assistance Program and Financial Assistance Fund) — 如果保險沒有承保全部費用，可幫助符合條件的個人支付骨髓或臍帶血移植的費用。造訪 www.bethematch.org 或致電 1-888-999-6743

美國罕見疾病組織 (NORD) — 協助患有某些疾病、而沒有保險或保險不足的人士取得所需的藥物。 www.rarediseases.org 或致電 1-800-999-6673

NeedyMeds.com — 提供關於藥物治療與病患計畫的資訊，說明如何申請每一項計畫。造訪 www.needymeds.com

處方藥協助夥伴 (Partnership for Prescription Assistance) — 協助取得免費或低價的處方藥。也提供連結至協助支付共付額的計畫。造訪 www.pparx.org 或致電 1-888-4PPA-NOW

患者權益基金會共付額援助計畫 — 幫助符合條件且被診斷某些疾病的人支付處方藥的共付額。造訪 www.copays.org 或致電 1-866-512-3861，選擇 1。

請致電 311 洽詢 HIICAP

Patient Services Incorporated (PSI) – May be able to assist people with certain chronic conditions by offering assistance with paying health insurance premiums and copayments/co-insurance, as well as costs related to travel. www.patientservicesinc.org or 1-800-366-7741

RX Hope – Apply for discounted and free medications directly through this website. www.rxhope.com or 1-877-979-4673

Together Rx Access – A prescription drug discount card available to people whose incomes meet the guidelines and who are not on Medicare and have no prescription drug coverage. www.togetherrxaccess.com or 1-800-444-4106

Other Internet Resources

Department of Labor - Information on COBRA, Black Lung, etc. – www.DOL.gov

Dental Plan Comparison – www.dentalplans.com

Health and Human Services Administration – www.hhs.gov

HealthFinder.gov – Access information specific to different health conditions

Families USA – Information on health care policy – www.familiesusa.org

Kaiser Family Network - Information on health care policy – www.kaisernetwork.org

National Health Policy Forum – www.nhpf.org

患者服務企業 (Patient Services Incorporated (PSI)) — 可幫助患有某些慢性疾病的人提供援助，支付健康保險保費和共付額/共同保險，以及差旅相關費用。造訪 www.patientservicesinc.org 或致電 1-800-366-7741

RX Hope — 直接通過該網站申請折扣藥品和免費藥品。造訪 www.rxhope.com 或致電 1-877-979-4673

製藥業共同處方取得計畫 (Together Rx Access) — 為收入符合規定且無聯邦醫療保險和處方藥保險的人士所提供的處方藥折扣卡。 www.togetherrxaccess.com 或 1-800-444-4106

其他網上資源

勞工部 — 提供關於 COBRA、塵肺症等資訊。 — www.DOL.gov

牙醫保險計畫比較 — www.dentalplans.com

健康與人類服務管理局 — www.hhs.gov

HealthFinder.gov — 提供不同病症的專門資訊

美國家庭聯盟 (Families USA) — 提供關於健保政策的資訊 — www.familiesusa.org

凱薩家庭網 (Kaiser Family Network) — 提供關於健保政策的資訊 — www.kaisernetwork.org

國家健康政策論壇 — www.nhpf.org

Medicaid Offices in New York City

Medicaid applicants can call the Medicaid Helpline at 1-888-692-6116 to find the nearest Medicaid office, office hours and directions. New York City residents can apply at any office in the five boroughs. Office hours are Monday-Friday, from 9 am – 5 pm.

Citywide Medicaid Office:

- Central Medicaid Office, 785 Atlantic Avenue, Brooklyn, NY 11238 1-888-692-6116

Manhattan

- Bellevue Hospital: 462 First Avenue & 27th Street, "G" Link, 1st Fl. (212) 679-7424
*At printing time, the Bellevue Hospital Medicaid is closed due to Hurricane Sandy. Call prior to visiting.
- Metropolitan Hospital: 1901 First Avenue, 1st Floor, Room 1D-27 (97th Street & 2nd Ave. entrance). (212) 423-7006
- Chinatown Medicaid Office: 115 Christie Street, 5 floor. (212) 334-6114
- Manhattanville Medicaid Office: 520-530 West 135th Street, 1st floor. (212) 939-0207/0208

Bronx

- Lincoln Hospital: 234 East 149th Street, Basement, Room B-75. (718) 585-7872/7920
- North Central Bronx Hospital: 3424 Kossuth Avenue, 1st Floor, Room 1A 05. (718) 920-1070
- Morrisania Diagnostic & Treatment Center: 1225 Gerard Avenue, Basement. (718) 960-2752/2799

Brooklyn

- Coney Island Medicaid Office: 3050 West 21st Street. (929) 221-3776
*The Coney Island Medicaid Office is also open on Saturdays, from 9 am – noon.
- East New York Diagnostic and Treatment Center: 2094 Pitkin Avenue, Basement. (718) 922-8292/8293
- Kings County Hospital: 441 Clarkson Avenue, "T" Building, Nurses Residence, 1st Floor. (718) 221-2300/2301
- Brooklyn South Medicaid Office (Central Medicaid Office): 785 Atlantic Avenue, 1st Floor. (888) 692-6116

Queens

- Queens Community Medicaid Office: 45-12 32nd Place (1st Fl.). (718) 752-4540

Staten Island

- Staten Island Medicaid Office: 215 Bay Street. (718) 420-4660/4732

紐約市醫療補助辦事處

醫療補助申請人可致電醫療補助專線 1-888-692-6116 以查詢距離最近的醫療補助辦事處、營業時間和前往指示。紐約市居民可以在五個行政區內任何辦事處申請。營業時間是星期一至星期五上午 9 時至下午 5 時。

全市醫療補助辦事處：

- 醫療補助中央辦公室(Central Medicaid Office), 785 Atlantic Avenue, Brooklyn, NY 11238 1-888-692-6116

曼哈頓

- 表維醫院 (Bellevue Hospital) : 462 First Avenue & 27th Street, "G" Link, 1st Fl. (212) 679-7424
*於印刷時，表維醫院因颶風桑迪而關閉。就診前請致電。
- 大都會醫院 (Metropolitan Hospital) : 1901 First Avenue, 1st Floor, Room 1D-27 (97th Street & 2nd Ave. 入口)。(212) 423-7006
- 華埠醫療補助辦事處 : 115 Christie Street, 5 floor。(212) 334-6114
- Manhattanville 醫療補助辦事處 : 520-530 West 135th Street, 1st floor。(212) 939-0207/0208

布朗士區

- 林肯醫院 (Lincoln Hospital) : 234 East 149th Street, Basement, Room B-75。(718) 585-7872/7920
- 布朗士中北區醫院 (North Central Bronx Hospital) : 3424 Kossuth Avenue, 1st Floor, Room 1A05。(718) 920-1070
- Morrisania 診斷和治療中心 : 1225 Gerard Avenue, Basement。(718) 960-2752/2799

布碌侖

- Coney Island 醫療補助辦事處 : 3050 West 21st Street。(929) 221-3776
*Coney Island 醫療補助辦事處星期六上午 9 時至中午亦開放。
- 東紐約診斷和治療中心: 2094 Pitkin Avenue, Basement。(718) 922-8292/8293
- 國王郡醫院 (Kings County Hospital) : 441 Clarkson Avenue, "T" Building, Nurses Residence, 1st Floor。(718) 221-2300/2301
- 布碌侖南部醫療補助辦公室 (醫療補助中央辦公室) : 785 Atlantic Avenue, 1st Floor。(888) 692-6116

皇后區

- 皇后區社區醫療補助辦事處 : 45-12 32nd Place (1st Fl.)(718) 752-4540

史坦登島

- 史坦登島醫療補助辦事處 : 215 Bay Street。(718) 420-4660/4732

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CALL 311 AND ASK FOR HIICAP

請致電 311 洽詢 HIICAP