Informational Update Vol 13 #4

1. **2021 Medicare Part B Reimbursement**

On or around April 15, 2022, Medicare-eligible retiree members and their Medicare-eligible dependents received the annual Part B standard reimbursement for 2021 of $1,782 ($148.50 x 12 months), except for those who were penalized or went on Medicare sometime during 2021. This group will receive a pro-rated amount, although the exact date when this will happen is unknown at this time.

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

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

2. **2021 IRMAA**

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

Medicare-eligible members and their Medicare-eligible dependents who filed an application in a timely manner, should receive their 2021 Medicare Part B IRMAA reimbursement in October 2022.

Those members who receive their pension payments electronically, will have their reimbursement deposited in their bank account. This amount is separate from the pension payment. Those who receive their pension checks in the mail, will have their IRMAA reimbursement mailed to them.

3. **<u>Something New: The $15 Copay</u>**

Effective January 1, 2022, members in Senior Care became responsible for a $15 copay for PCP and specialist services. These co-payments are supposed to start after the $233 Medicare deductible and $50 Emblem Health deductible have been met.

Unfortunately, there have been some problems associated with co-payments which I can best explain by example.

1. The doctor charges you a $15 copay for a visit even though you have not met your deductible. This is an example of you paying twice – once for your $15 copay and the 2nd to meet your deductible.
2. The doctor charges you a $15 copay. According to Emblem Health's Summary of Claims, they allow for the service 11.91, a difference of $3.09.

The only way you can resolve these issues is by apprising your doctors' offices. The offices should give you credit if you paid a copay before you met your deductible or paid more than you should have. I also strongly suggest you review your Emblem Health Summary of Claims and keep track of your co-payments.

4. **Question of the Month**

I was told by Express Scripts recently that one of my drugs, which is extremely expensive, will not be covered when I go on Medicare unless I try 4 drugs from my preferred list. I do not wish to try these drugs as they may have serious adverse side effects. Should I look for another drug plan that covers this drug?

That is entirely up to you. If you feel the drug will be too costly, you may drop the GHI/Express Scripts plan when you go on Medicare and enroll directly with a plan that covers your drug. Since you will no longer be enrolled in the GHI/Express Scripts plan, the Fund will continue to reimburse 80% of your copays after an annual $100 deductible up to $10,000. The Retiree Chapter will also continue to reimburse you an additional 20% of whatever the Fund reimburses you.

Since you will longer be in the GHI/Express Scripts plan, you no longer will receive the $40 per month "Valentine" gift. You may, however, re-enroll in the drug plan each year during the transfer period should you desire to do so.

Have a great & safe day,

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