Section IX

Health Insurance
Additional Low-Income Medicare Beneficiary Program
(ALMB, Qualified Individual QI-1)

Description:
The Additional Low-Income Medicare Beneficiary program (ALMB, QI-1), offered by the Department of Social Services, pays the Medicare Part B premium for certain low income Medicare beneficiaries. The ALMB program is available to elderly individuals and those with disabilities who receive Social Security benefits and are eligible for Medicare benefits. The program is subject to available funding.

Eligibility Requirements, Service Areas and Program Year:

Eligibility Requirements:
- Must meet income limits. Monthly gross income includes Social Security, pensions, disability benefits, wages, alimony, rental income, interest and dividends. The income limit for a single person is $1,497.05. This amount includes one unearned income disregard of $278, which most people receive. The income limit for a couple is $2,196.25. This amount includes two unearned income disregards for a total of $556. Income limits are updated every April.
- Eligibility also depends on available program funding.
- Eligibility must be determined annually.
- An individual is not eligible for this program if receiving Medicaid.

Service Areas:
Statewide

Program Year:
Income requirements are updated April 1.

Contact Information:
The local Department of Social Services' Regional Offices listed in Appendix A.

Related Information:

Medicare, refer to page IX – 9.
Social Security, refer to page VI – 7.
Specified Low-Income Medicare Beneficiary/SLMB Program, refer to page IX – 22.
Description:

Charter Oak Health Plan is Connecticut’s medical insurance program for individuals age 19 through 64 who are uninsured or are experiencing financial hardship in paying unaffordable, non-group premiums on their own. Connecticut has contracted with three private insurers, Aetna Better Health, AmeriChoice by UnitedHealthcare and Community Health Network of Connecticut, to coordinate health insurance benefits and medical providers. Eligible individuals must choose from one of these three insurers. Affiliated Computer Services, Inc. determines eligibility for the Charter Oak Health Plan. There is a six month period of ineligibility for individuals who drop existing medical coverage in order to qualify for Charter Oak, however there are some exceptions to this policy. Individuals receiving Medicare insurance are not eligible for Charter Oak. Individuals receiving Social Security Disability or State Supplemental Income are referred to the Department of Social Services for Medicaid. Those with very low incomes are referred to the Department for SAGA provided they have limited assets.

Individuals with pre-existing medical conditions can apply for and receive coverage under Charter Oak. There is no asset test or income requirement. The amount of income a person has, however, determines the premium and deductibles for which she/he is responsible. Deductible amounts apply to inpatient hospital care, outpatient surgical care and inpatient rehabilitation and skilled nursing. Where applicable, co-payments will remain the same throughout the eligibility period.

Charter Oak Health Plan benefits include but are not limited to:

- Primary care office visits with $25 co-pay.
- Specialist office visits with $35 co-pay.
- Preventive care visits are covered 100 percent.
- Behavioral health through the Connecticut Behavioral Partnership with $35 co-pay.
- An ambulance is covered 100 percent in emergencies.
- Prescription medication with a three-tiered payment system.
- Durable medical equipment with a $4,000 annual limit.
- Maternity pre-and post-care is covered 100 percent.
- Inpatient hospital care is covered 90 percent after the deductible is met.
- Outpatient surgery is covered 80 percent after the deductible is met.
- Inpatient rehabilitation and skilled nursing is covered 80 percent after the deductible is met.

Eligibility Requirements, Service Areas and Program Year:

Eligibility Requirements:
- Must be a Connecticut resident.
- Must be between the ages of 19 and 65.
- Must not have dropped cost-effective group medical insurance in order to qualify for the Charter Oak Health Plan unless certain criteria are met.
- Eligible persons must choose one of the three managed care plans available through the Charter Oak program.
- Must pay monthly premiums; when premiums are not paid, recipients are locked out of the program for three months and past-due premiums must be paid prior to re-enrollment.
- There is no income requirement or asset test. Family size and income determine premiums and deductibles.
- The Charter Oak Health Plan does not provide retroactive coverage.
- Self-employment income must be verified.

Service Areas:
Statewide

Program Year:
July – June

**Contact Information:**

For information or an application call 1-877-CTOAK or 1-877-772-8625. An application can also be downloaded from [www.charteroakhealthplan.com](http://www.charteroakhealthplan.com)

Completed and signed applications should be sent to:

Charter Oak Health Plan
P.O. Box 280747
East Hartford, CT 06128

**Related Information:**

*CHOICES, refer to page XIII – 5.*
Connecticut Partnership for Long-Term Care

Description:

The Connecticut Partnership for Long-Term Care is a State of Connecticut program conducted in cooperation with the private insurance industry to help Connecticut residents finance future long-term care without risk of impoverishment. The Department of Social Services, Aging Services Division offers free publications, counseling and public-information programs to provide unbiased information to help people make decisions about financing long term care. Trained volunteers are available to meet personally with individuals to help them discuss long-term care planning and evaluate long-term care insurance policies. Volunteers assist consumers in understanding relevant material; they do not make decisions or choices for them. Volunteers do not make decisions or choices for the individuals they assist; and they do not sell insurance policies.

Ten private insurance companies competitively sell Connecticut Partnership-approved long-term care insurance policies. These policies have higher consumer protection standards than non-Partnership policies and include a Medicaid Asset Protection benefit. This benefit allows individuals to apply for Medicaid to pay for long-term care expenses after their insurance policies end without having to deplete all their assets to qualify. When determining eligibility, Medicaid will disregard assets persons have up to the amount that their Partnership policies paid in benefits. Insurance companies set their own criteria for selling policies based upon age, health status and mental condition. Prices for premiums vary and consumers are encouraged to shop for comparisons.

Eligibility Requirements, Service Areas and Program Year:

Eligibility Requirements:

- Applicants of long-term care insurance policies must provide a health statement from a physician and/or submit to a physical exam. They also must meet the eligibility criteria established by the insurance company that holds the policy that is being considered.

To purchase a Partnership Policy:

- Must be a Connecticut resident when the policy is purchased and applying for Medicaid.
- Must meet the policy’s age requirement and be in generally good health.
- Must have the ability to pay the premiums.
- Should have at least $75,000 in assets.
Service Areas:
Statewide

Program Year:
N/A

**Contact Information:**

For free information packets, call 1-800-547-3443.

The Connecticut Partnership for Long-Term Care
Department of Social Services
Aging Services Division
25 Sigourney Street
Hartford, CT 06106
Telephone: 800-547-3443 or 860-424-5023
Fax: 860-424-5301
Website: [www.ctpartnership.org](http://www.ctpartnership.org)

**Related Information:**

N/A
Medicaid (Title XIX)

Description:
The Medicaid program is designed to help persons who are age 65 years or older, persons, with disabilities between the ages of 18 and 65, those who are blind or who receive public assistance to pay medical expenses. Medicaid is funded by the Federal and State governments. There are different eligibility requirements for persons who live in the community and those who require long term care. Long term care is defined as either the admission to a long term care facility or the receipt of home and community based services.

Eligibility Requirements, Service Areas and Program Year:

Eligibility Requirements:
Persons Residing in the Community:
- Individuals’ assets cannot exceed $1,600; married couples living together may not have assets of more than $2,400.
- The cash surrender value of life insurance is excluded if the face value of all such policies is less than $1,500. If the face value exceeds the $1,500 limit, the cash surrender value of the policy is counted toward the asset limit. Term Life Insurance is not counted.
- Up to $1,800 of a burial fund is excluded as an asset.
- Up to $5,400 of an irrevocable burial fund is excluded as an asset.
- Home property is totally excluded as an asset in the Medicaid Program.
- Income requirements are based on where applicants live within the community.
- Single persons’ monthly incomes cannot exceed:
  - Region A: $610.61
  - Regions B and C: $506.22
- Couples’ monthly incomes cannot exceed:
  - Region A: $777.92
  - Regions B and C: $672.10

Persons Requiring Long Term Care:
- Institutionalized individuals’ countable assets cannot exceed $1,600.
- The cash surrender value of life insurance policies is excluded as assets if the total face value of all such policies does not exceed $1,500.
- Up to $1,800 of a burial fund is excluded as an asset.
- Up to $5,400 of an irrevocable burial fund is excluded as an asset. A burial plot
is defined as the purchase of a grave site, opening and closing of a grave site, cremation urn, casket, outer burial container and a headstone or marker, including a contract to provide the aforementioned items. A grave may include a crypt or mausoleum.

- Individuals who entered institutions on or after September 30, 1989 who have spouses living in the community are allowed to have a portion of the couple’s combined assets protected for the use of the community spouse. The amount of the assets that is protected is called the Community Spouse Protected Amount (CSPA). The value of the protected assets is not counted when eligibility for the institutionalized individual is determined. The maximum and minimum amounts are set by Federal law. The State is required to update these amounts annually. Only a Fair Hearing Decision or Court Order can allow the CSPA to exceed the amount set by Federal law. When institutionalized individuals and their spouses have assets that exceed the amount established as the CSPA and the $1,600 asset limit, the excess assets are considered to be available to the institutionalized spouse. This applies regardless of which spouse owns the assets. Institutionalized individuals are not eligible for Medicaid until the couple’s assets are reduced to the total amount of the $1,600 asset limit and the CSPA. Excess assets may be spent down in any way the couple wishes as long as fair market value is received.

When institutionalized individuals have spouses who live in the community, some of the institutionalized person’s income can be used for the spouse’s needs. This income is called a Community Spouse Allowance (CSA); it is determined by subtracting the community spouse’s monthly gross income from the community spouse’s Minimum Monthly Needs Allowance (MMNA). The MMNA is calculated according to a formula that uses the spouse’s actual monthly shelter costs, which includes an allowance to cover monthly utility costs. The maximum and minimum MMNA amounts are set by Federal law; the State is required to update the amounts annually. The MMNA cannot exceed the maximum amounts set, except by a Fair Hearing decision.

When institutionalized individuals apply for Medicaid, DSS examines any transfers of assets made by these individuals and their spouses up to 60 months immediately before the date such persons applied for Medicaid and were institutionalized. Not all asset transfers are considered improper if an improper transfer is made, a penalty period is established during which time the Department will not pay for long term care or home care.

Service Areas:
Region A
Bethel Darien New Canaan
Bridgewater Greenwich Newtown
Brookfield New Milford Norwalk
Danbury New Fairfield Redding

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Region B and C
All towns not listed in Region A should use the income limits shown for Regions B and C.

Program Year:
July 1 – June 30

Contact Information:

To apply for Medicaid contact the local DSS office, refer to Appendix H.

Individuals who encounter problems obtaining Medicaid or who are denied benefits are entitled to a Fair Hearing. Local legal service offices can assist persons who need help pursuing a Fair Hearing. Consult Legal Assistance for Older Persons on page XIV - 20 for a listing of the nearest legal services office.

To request a Fair Hearing, you may contact:

State of Connecticut
Department of Social Services
Administrative Hearings and Appeals
25 Sigourney Street
Hartford, CT 06106-5033

Related Information:

BenefitsCheckUp (and BenefitsCheckUpRx), refer to page XIII – 3.
Medicare

Description:
Medicare is a national health insurance program for persons age 65 or older and for certain persons with disabilities. Medicare has two parts, A and B. Connecticut beneficiaries have the option of receiving benefits through the original fee-for-service plan or choosing coverage through a Medicare managed care plan. Persons who enroll in Medicare automatically become a part of the fee-for-services program unless they choose to enroll in a Medicare managed care plan. The original fee-for-service program is similar to indemnity insurance in that it helps to cover the medically necessary expenses of acute care, such as illness. Although it provides basic coverage, it does not pay 100 percent of health care costs. Deductibles and co-insurances apply to certain benefits under both Parts A and B. In the fee-for-service program, a beneficiary can receive services from any licensed medical provider anywhere in the country and use any facility that is certified by Medicare. Generally, a fee is paid each time a service is used. Medicare pays a share of the cost; the beneficiary pays whatever Medicare does not.

Both plans provide basic Medicare benefits for hospital and medical services; but there are important differences among these plans in the way services are delivered, how and when payments are made and the amount of out of pocket expenses beneficiaries must pay. Persons are still eligible for Medicare at age 65, however, they must file an application to receive these benefits even if their full retirement age for Social Security benefits is older than 65. Persons already receiving Social Security or Railroad Retirement Board benefits automatically get Part A beginning the first day of the month in which they turn age 65 and the option to have Part B. Persons who are younger than age 65 and have disabilities are eligible for Part A and part B when they have received Social Security disability or Railroad Retirement benefits for 24 months.

Medicare Part A: Hospital
Medicare Part A covers inpatient hospital care, hospice care, some short-term inpatient care in skilled nursing facilities and some home health care services. Part A is largely financed through federal payroll taxes that are paid into the Medicare Trust Fund by employers and employees. Most beneficiaries automatically receive Part A coverage when they reach age 65. Most of the individuals do not have to pay a monthly premium. Persons age 65 or older who did not pay Medicare taxes when they worked and have not accumulated enough Social Security credit may choose to purchase Part A. Persons who are close to age 65 but are not receiving these benefits should apply for them through the Social Security Administration. Persons with Part A coverage have “Hospital Part A” printed on the lower left corner of their red, white and blue Medicare card.
Medicare Part A pays partial costs of certain services from a hospital, skilled nursing facility, hospice and home health agency. There is a substantial deductible for each benefit period ($1,068 in 2009) and a co-insurance share of daily costs if hospitalized for more than 60 days in a benefit period.

Part B: Medical/Physician:
Medicare Part B is optional; it covers a wide range of services and supplies which includes, services provided by doctors and other medical practitioners, some outpatient care, certain home health care services and some preventative benefits as well as durable medical equipment. This coverage is financed partially by monthly premiums that are paid by all beneficiaries and partially by general revenues from the federal government. There is a monthly premium for Part B, which is $96.40 (2009). Some people with high incomes pay higher Part B premiums. This amount might also be higher for persons who did not choose Part B when they first became eligible at age 65. Costs may increase by 10 percent for each 12-month period a person could have enrolled in Part B but did not. Individuals who are automatically eligible for Part A are also enrolled in Part B unless they inform Social Security not to do so. New premium rates become effective each January. New rates are sent to beneficiaries in December with their cost of living adjustment notice. Premiums are usually deducted from persons' monthly Social Security, Railroad Retirement or Office of Personnel Management Retirement payments. For those who do not receive such payments, Medicare bills quarterly for coverage.

Part B pays for a wide range of medical services and supplies, including doctor's care, whether such care is received at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. In 2009, there is a $135 deductible which must be paid each year before Part B begins to pay its share of covered services. After the deductible is met, Part B generally pays 80 percent of the Medicare-approved amount for all covered services received during the rest of the year. The beneficiary is responsible for the remaining 20 percent and any amount in excess of what Medicare has approved. There are no excess charges, however, if the physician or medical supplier agrees to accept the Medicare-approved amount as full payment. This is referred to as "accepting assignment".

Medicare covers certain preventive health care screening tests for which the Part B deductible and co-insurances may be waived for some of these services. These include:

- Annual mammography screening.
- Pap smear and pelvic exam screening.
- Colorectal cancer screening.
- Diabetes screening tests and self-management training.
- Bone mass measurement.
- Prostate cancer screening tests.
- A one time "welcome to Medicare" physical which must be used within the first six months of being enrolled in Medicare Part B.
Medicare Part D: Prescription Drug
Medicare prescription drug coverage, also known as Medicare Rx, pays for prescription drugs, insulin and insulin supplies and smoking cessation drugs for Medicare beneficiaries. Medicare contracts with private companies to provide this drug coverage. In 2009 there are 47 Prescription Drug Plans (PDPs) and 32 Medicare Advantage Plans (HMO, PPO and PFFSs) that offer prescription drug coverage in Connecticut. Most companies offer several plans with different levels of coverage and costs. Some employers may “wrap-around” the program to offer coverage through their retirement health plans, meaning that whatever costs part D does not cover, the employer offered plan would.

Medicare beneficiaries must enroll in a PDP to have Medicare provide prescription drug coverage. There are guidelines concerning when a beneficiary can enroll in a Medicare prescription drug plan as well as when and how often an individual can change plans.

Beneficiaries are penalized one percent per month for each month that they could have enrolled in a Medicare prescription drug plan but did not. Plans issue ID cards to enrollees that are used at the pharmacy; some cards allow members to receive prescriptions by the mail.

Medicare Part D covers most outpatient prescription drugs, insulin and insulin supplies and smoking cessation drugs. Medicare approved plans offer their own selection of covered drugs, which is called a “formulary”. Formularies vary from plan to plan. These plans offer a choice of at least two drugs in each of the 146 categories of drugs. Plans also include their own formulary for drugs in the following six categories of drugs: anti-depressants, anti-psychotics, anti-convulsants, anti-cancer, immuno-suppressants and HIV/AIDS. Medicare Part D does not cover some drugs. Some plans may cover certain excluded drugs as an enhanced benefit for an additional charge. Medicaid and ConnPACE also cover some of these drugs for their consumers.

The Medicare Part D “standard benefit” includes an annual deductible. In 2009 this deductible cannot exceed $295 per year. Beneficiaries must meet their plans specific annual deductible before Part D coverage begins. When the deductible is met, the “initial benefit period” begins at which time Medicare pays 75 percent of each prescription drug; the beneficiary pays 25 percent for the next $2,405 in drug costs. Then a coverage gap or “donut hole” in which the beneficiary pays 100 percent of all prescription costs until another $3,453.75 out of pocket has been spent. Some plans may pay for prescription costs during the coverage gap. Once the beneficiary has spent a total of $4,350 in allowable “true-out-of-pocket costs” (TrOOP), “Catastrophic Coverage” begins and for the remainder of the year Medicare pays 95 percent of prescription drug costs and the beneficiary pays 5 percent of each prescription, $2.40 or $6 co-pay, whichever is greater.

Individuals who receive benefits from ConnPACE, Medicaid, a Medicare Savings Program (QMB, SLMB, ALMB/QI) or Supplemental Security Income (SSI) are automatically enrolled in a Medicare prescription drug plan if they do not select a plan
on their own. Dual eligible individuals may switch plans one time per month; the change is effective the first day of the following month.

All plans have co-pays or co-insurances that beneficiaries are responsible to pay for each prescription. Beneficiaries with limited income and assets may qualify for Extra Help to assist them in paying the premiums, deductibles, co-pays and co-insurance. Persons can apply for Extra Help at their local Social Security office.

**Medigap:**

Many other medical expenses, such as self-administered prescription drugs, dental care, and routine physicals are not covered either through Part A or Part B. To help pay for these out of pocket expenses, beneficiaries often buy supplemental private insurance policies, called Medigap. For more information about Medigap insurance, please refer to the section of this Manual called "Medigap Insurance Policies."

**Medicare Managed Care Plans:**

Connecticut beneficiaries have the option of receiving Medicare services through one of several federally approved Medicare managed care plans. Unlike fee-for-service, these plans are “preventive” in nature and attempt to coordinate all health care services an individual receives to maximize benefits and minimize costs. To achieve these goals, plans use a limited network of health care providers and facilities and a system of “prior approval” from a primary care physician, sometimes referred to as a “gatekeeper”. Primary care physicians authorize, arrange for, and coordinate care that they decide is reasonable and necessary.

Most managed care plans in Connecticut require an additional monthly premium, especially if there is a prescription drug benefit included in the plan. Plans require co-payments for physician visits or for the use of other services. Individuals must continue to pay the Medicare Part B premiums; but they do not have to pay the deductible and co-insurance under Medicare’s original fee-for-service. Benefits vary from plan to plan, however, each plan is required by Medicare law to provide all of the Medicare benefits that are generally available in the plan’s service area.

All plans have a “lock-in” requirement, which means that individuals generally must receive all covered care from doctors, hospitals, and other health care providers that are affiliated with the plan. Exceptions include emergency care, urgent care and certain care provided under an additional “point of service” (POS) option.

If individuals enroll in a Medicare managed care plan and later decide to return to Medicare’s original fee-for-service, they may disenroll at any time. Certain time restrictions on this policy will be phased out. Persons who do this may be limited in the available Medigap policies from which they can choose. Persons who want to change from one Medicare managed care plan to another may do so by enrolling in the other plan; this action automatically disenrolls them from the first plan. Persons whose Medicare managed care plan no longer provides coverage in their region also have
options available to them. Contact the CHIOCES program at 800-994-9422 for more information on these situations.

To enroll in a Medicare managed care plan individuals must be enrolled in Medicare Parts A and B, continue to pay Part B premiums and not be medically determined to have end-stage renal disease prohibition. Persons may not be denied membership because of otherwise poor health, a disability or other pre-existing conditions.

Choosing the Best Medical Plan:
Both the original fee-for-service Medicare and Medicare managed care plans have advantages and disadvantages depending upon individual's personal circumstances. Information detailing each program option, including plan comparison guides and other considerations as well as general assistance can be obtained through the CHOICES programs.

Beneficiaries should read program materials, ask questions and consider the important personal aspects of each option to make sure the best medical program is chosen.

Eligibility Requirements, Service Areas and Program Year:

Eligibility Requirements:
- Must be age 65 or older or have certain disabilities.

Service Areas:
Statewide

Program Year:
N/A

Contact Information:
Call 1800-medicare or go to www.Medicare.gov

For Social Security offices and information regarding Medicare, contact the Social Security offices below:

District and Branch Offices in Connecticut:

Ansonia:          Bridgeport:
307 Main Street   3885 Main Street, 3rd Floor
Ansonia, CT 06401  Bridgeport, CT 06606
Telephone: 203-735-6201  Telephone: 203-365-8452
Bristol:
225 North Main Street, Room 400
Bristol, CT 06010
Telephone: 860-584-2716

Danbury:
131 West Street
Danbury, CT 06810
Telephone: 203-748-3569

East Hartford:
478 Burnside Avenue
East Hartford, CT 06108
Telephone: 860-290-5420

Hartford:
One Corporate Center
20 Church Street, Suite 900
Hartford, CT 06103
Telephone: 860-493-1857

Meriden:
One West Main Street, 4th Floor
Meriden, CT 06451
Telephone: 203-238-0346

Middletown:
425 Main Street, 3rd floor
Middletown, CT 06457
Telephone: 860-347-8562

New Britain:
100 Arch Street
New Britain, CT 06050
Telephone: 860-229-4844

New Haven:
150 Court Street, Room 325A
New Haven, CT 06510
Telephone: 203-773-5201

New London:
2 Shaw’s Cove, Room 203
New London, CT 06320
Telephone: 860-443-8455

Norwich:
Thames Plaza
101 Water Street, 3rd floor
Norwich, CT 06360
Telephone: 860-886-7118

Norwalk:
24 Belden Avenue, 5th floor
Norwalk, CT 06850
Telephone: 203-849-1911

Stamford:
2 Landmark Square, Suite 105
Stamford, CT 06901
Telephone: 203-359-0030

Torrington:
147 Litchfield Street
Torrington, CT 06790
Telephone: 860-489-1633

Waterbury:
14 Cottage Place
Federal Building, Room 255
Waterbury, CT 06702
Telephone: 203-756-7476

Willimantic:
54 North Street
Willimantic, CT 06226
Telephone: 860-423-6386

Contact Information:

For information regarding the CHOICES program and general questions about Medicare refer to CHOICES on page XIII – 5 in this manual.
For further information on accepting assignment refer to ConnMAP on page VIII 8 of this manual.

For an explanation of supplemental private insurance policies refer to Medigap Insurance Policies on page IX – 16 of this manual.

Related Information:

Center for Medicare Advocacy, refer to page I – 3.
Medigap Insurance Policies

Description:

Medigap, also referred to as Medicare Supplement Insurance, supplements Medicare benefits for Medicare beneficiaries. Medicare generally does not cover the total costs of healthcare. Medigap insurance policies address some of these gaps in coverage. Medigap policies only work with original Medicare and do not work with Medicare managed care plans.

Twelve standardized Medigap insurance policies are offered in Connecticut; they are identified by letters A through L. Policy A only provides basic benefits while policies B through J contain basic as well as additional benefits. As of January 1, 2006 no Medigap policies offer prescription drug coverage.

The basic benefits include:

- Hospitalization: Part A coinsurance plus coverage for 365 additional lifetime days after Medicare benefits end
- Medical: Part B coinsurance, which is generally 20 percent of Medicare-approved expenses
- Blood: First three pints of blood each year

Any company in Connecticut that offers Medigap insurance products is required to at least offer the basic benefits (Policy A) to Medicare beneficiaries over age 65. Many companies also choose to offer some of the policies B through L. Companies which offer policies A, B, or C to Medicare beneficiaries over age 65 must also offer the policies to Medicare beneficiaries with disabilities regardless of age.

Companies cannot deny coverage to persons age 65 and older within the first six months during which an applicant is both 65 and enrolled in Medicare Part B. In addition, for Medicare beneficiaries who are over age 65, coverage may not be denied at any time for policies A through G because of age, gender, previous claim history or medical condition. However, for policies H – L, after the first six months during which a Medicare beneficiary is both 65 and enrolled in Medicare Part B, coverage may be denied because of a previous claim history or a medical condition.

There may be a waiting period of up to six months for coverage of a pre-existing condition. Under certain circumstances Federal law provides protections under which limitations on coverage may not be imposed for pre-existing conditions. More details on these protections can be found in materials available from CHOICES (1-800-994-9422).

It is unlawful for a company to sell a duplicate Medicare supplement policy to a Medicare beneficiary. However, if a beneficiary is covered under a retiree health plan
and is considering the purchase of a Medigap policy, she/he may wish to ask for additional information.

At the time of application, applicants should expect to receive an outline of coverage, which provides information on future premium changes, a policy summary and notice that the policy may be returned with a full refund within 30 days after receipt. Applicants should answer all questions on the application fully and truthfully and should not cancel existing policies until they are sure when the replacement policy is effective.

No one should ever be pressured into purchasing a Medigap policy. It is important for consumers to compare costs and benefits of policies before making a purchase and to understand the circumstances under which a company can raise its premium.

Under Connecticut law, any person who feels that she/he has made a mistake in purchasing a policy has 30 days from the receipt of the policy to return it for a full and timely refund.

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**Eligibility Requirements, Service Areas and Program Year:**

**Eligibility Requirements:**
- Must be enrolled in Medicare.

**Service Areas:**
- Statewide

**Program Year:**
- N/A

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**Contact Information:**

For more information about Medicare supplement policies including additional regulatory standards and a rate comparison guide; contact the CHOICES program at the regional Area Agency on Aging. See Appendix A for a listing of towns served by each agency.

**Senior Resources Eastern Connecticut Area Agency on Aging**
- 4 Broadway, 3rd Floor
- Norwich, CT 06360
- Telephone: 860-887-3561
- Fax: 860-886-4736
- Website: [www.seniorresourcesec.org](http://www.seniorresourcesec.org)

**North Central Connecticut Area Agency on Aging**
- 2 Hartford Square West, Suite 101
- Hartford, CT 06106
- Telephone: 860-724-6443
- Fax: 860-251-6107
- Website: [www.ncaaact.org](http://www.ncaaact.org)
Agency on Aging of South Central Connecticut, Inc.
One Long Wharf Drive
New Haven, CT 06511
Telephone: 203-785-8533
Fax: 203-785-8873
Website: www.aoapartnerships.org

Southwestern Connecticut Agency on Aging
10 Middle Street
Bridgeport, CT 06604
Telephone: 203 333-9288
Fax: 203 696-3866
Website: www.swcaa.org

Western Connecticut Area Agency on Aging
84 Progress Lane
2nd Floor
Waterbury, CT 06705
Telephone: 203 757-5449
Fax: 203 757-4081
Website: www.wcaaa.org

Related Information:

Medicare, refer to page IX – 9.
Qualified Medicare Beneficiary (QMB) Program, refer to page IX – 19.
Qualified Medicare Beneficiary (QMB) Program

Description:
The Qualified Medicare Beneficiary (QMB) program pays the Medicare Part A and Part B monthly premiums and for coinsurance and deductible amounts for services covered under Medicare for individuals who use Medicaid providers. Coinsurance is the portion of Medicare approved services that an individual is responsible to pay. This is usually 20 percent of the approved Medicare charge, up to the Medicaid approved rate.

The QMB program is available to all people who are eligible for Medicare Part A and who meet income and asset requirements. The QMB program offers equivalent benefits of some Medigap insurance coverage.

Eligibility Requirements, Service Areas and Program Year:

Eligibility Requirements:
- Eligibility is related to assets and monthly gross income.
- Must meet income limits. Monthly gross income includes Social Security, pensions, disability benefits, wages, alimony, rental income, interest and dividends. The income limit for a single person is $1,181. This amount includes one unearned disregard of $278, which most people receive. The income limit for a couple is $1,771. This amount includes two unearned income disregards for a total of $556. Income limits are updated every April.
- Must meet asset requirements. The asset limit for a single person is $4,000; it is $6,000 for a couple.

Service Areas:
Statewide

Program Year:
Income requirement are updated April 1.

Contact Information:
Contact one of the Department of Social Services Regional Offices in Appendix H.

Related Information:

Medicare, refer to page IX – 9.
Medigap Insurance Policies, refer to page IX – 16.
Senior Medicare Patrol (SMP)

Description:
Senior Medicare Patrol (SMP) Projects nationwide are funded by the federal Administration on Aging and are intended to empower older adults to address issues of healthcare fraud, errors, abuse and scams. In Connecticut, this project is part of the CHOICES family of programs operated by the Aging Services Division of the Connecticut Department of Social Services and the regional Area Agencies on Aging. Staff and volunteers provide education, assistance and advocacy to Connecticut residents so that they can identify, report and prevent Medicare and Medicaid fraud, waste and abuse and other scams, such as identity theft, that may have an impact on personal and agency healthcare financing. Senior Medicare Patrol recruits and trains program staff and volunteers to provide one-on-one counseling to older persons and their caregivers or family members to help them understand their health care documents. Staff and volunteers also give presentations that are intended to increase the public’s awareness and detection of fraud, waste and abuse to help recover federal and state dollars.

Eligibility Requirements, Service Areas and Program Year:

Eligibility Requirements:
- Must be a Medicare or dually-eligible beneficiary or an individual seeking information on behalf of a Medicare beneficiary.

Service Areas:
Statewide

Program Year:
October 1 – September 31

Contact Information:
To report suspected instances of healthcare fraud, waste or abuse, or to receive information on becoming a volunteer counselor contact the local Area Agency on Aging. Refer to Appendix A for towns served by each agency.
Agency on Aging of South Central Connecticut, Inc.
Coordinator: Leslie Pruitt
One Long Wharf Drive, Floor 2
New Haven, CT 06511
Telephone: 203-785-8533
Fax: 203-785-8873

North Central Connecticut Area Agency on Aging
Coordinator: Lindsay Quillen
New Park Office and Conference Center
151 New Park Avenue, Suite 15
Hartford, CT 06106
Telephone: 860-724-6443
Fax: 860-251-6107

Senior Resources Eastern Connecticut Area Agency on Aging
Coordinator: Betty Koski
4 Broadway, 3rd floor
Norwich, CT 06360
Telephone: 860-887-3561
Fax: 860-886-4736

Southwestern Connecticut Agency on Aging
Coordinator: Gail Diaz
10 Middle Street
Bridgeport, CT 06604
Telephone: 203-333-9288
Fax: 203-696-3866

Western Connecticut Area Agency on Aging
Coordinator: Dawn Macary
84 Progress Lane
2nd Floor
Waterbury, CT 06705
Telephone: 203-757-5449
Fax: 203-757-4081

Related Information:

N/A
Specified Low-Income Medicare Beneficiary (SLMB) Program

Description:
The Department of Social Services administers the Specified Low-Income Medicare Beneficiary (SLMB) program, which pays the Medicare Part B premium for certain low-income Medicare beneficiaries. The SLMB program is available to older adults as well as those with disabilities who receive Social Security benefits and are eligible for Medicare benefits.

Eligibility Requirements, Service Areas and Program Year:

Eligibility Requirements:
- Eligibility is related to assets and monthly gross income.
- Must meet income limits. Monthly gross income includes Social Security, pensions, disability benefits, wages, alimony, rental income, interest and dividends. The income limit for a single person is $1,361.60. This amount includes one unearned income disregard of $278, which most people receive. The income limit for a couple is $2,014. This amount includes two unearned income disregards for a total of $556, which most people receive. Income limits are updated every April.
- Must meet an asset requirement. The asset limit for a single person is $4,000; for a couple it is $6,000.

Service Areas:
Statewide

Program Year:
Income requirements are updated April 1.

Contact Information:
For more information contact the local DSS Regional Offices listed in Appendix H.

Related Information:

Additional Low-Income Medicare Beneficiary Program, refer to page IX – 1.
Medicare, refer to page IX – 9.
Qualified Medicare Beneficiary (QMB) Program, refer to page IX – 19.