EPIC 2023

Guide to the **Elderly Pharmaceutical Insurance Coverage** program **(EPIC)**

Updated 1/23

Courtesy of:

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EPIC

EPIC is New York State's prescription plan for seniors. It helps more than 325,000 income-eligible New Yorkers aged 65 and older supplement their out-of-pocket Medicare Part D drug plan. It provides copayment assistance for Medicare Part D-covered prescription drugs after any Part D deductible is met. EPIC also covers many Medicare Part D-excluded drugs. **It's easy to join the program. Just complete the application inside and mail or fax it to EPIC.**

For more information on the 2023 EPIC program, visit *health.ny.gov/health_care/epic/member_info/program_highlights_2023.htm* or call 1-800-332-3742 (TTY 1-800-290-9138).

Eligibility

New York State residents aged 65 and older who are not receiving full Medicaid benefits and whose income is up to $75,000 if single or $100,000 if married, are eligible.

You can apply for EPIC at any time of the year and must be enrolled or eligible to be enrolled in a Medicare Part D drug plan to receive EPIC benefits and maintain coverage.

Since EPIC is a qualified State Pharmaceutical Assistance Program (SPAP), EPIC members can change their Medicare Part D plan one time during the year, in addition to the open enrollment period.

EPIC and Medicare Part D

EPIC pays the monthly Medicare Part D plan premiums, up to the average cost of a basic plan, for members with an annual income up to $23,000 if single or $29,000 if married.

Those with higher incomes must pay their Part D plan premiums. Therefore, to help seniors with incomes higher than $23,000 if single or $29,000 if married, EPIC will lower the deductible to help them pay.

EPIC Copayments

Up to:	You pay:
$15	$3
$15.01-$35	$7
$35.01-$55	$15
$55.01 and over	$20

NEW YORK STATE | **EPIC** Elderly Pharmaceutical Insurance Coverage Program

Application

NEED HELP? CALL TOLL-FREE: 1-800-332-3742
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Please print clearly!

Who is applying and for? ☐ Yourself **only** ☐ Yourself **and your spouse** ☐ "Extra Help" **only**

Your Last Name | First | Middle Initial

c/o Name (if different from above)

Address Where You Live (not P.O. Box)

City | State | ZIP Code

Address Where You Get Your Mail (if different from above)

City | State | ZIP Code

Social Security Number

Sex
☐ Female ☐ Male ☐ X

Your Date of Birth
Month / Day / Year

Your Telephone Number
Area Code Number
( )

Marital Status
☐ Widowed, Single or Divorced
☐ Married, Living Together
☐ Married, Living Separately

Spouse's Name (If Living)
Last Name | First | Middle Initial

Spouse's Telephone Number
Area Code Number
( )

Spouse's Social Security Number

Spouse's Date of Birth
Month / Day / Year

Spouse's Sex
☐ Female ☐ Male ☐ X

Enter your Medicare Claim Number (blue, white and red card) _____

Enter your Spouse's Medicare Claim Number (blue, white and red card) _____

If you already have EPIC, enter your EPIC Identification Number _____

If your spouse has EPIC, enter your Spouse's EPIC Identfication Number _____

EPIC Determination: Report your total income for the previous calendar year.

If you are married, and living together, you must report the combined yearly income for the previous year for you and your spouse even if only one of you is applying. If married but living apart, report only your yearly income. Multiply monthly amounts by 12 to get yearly income. Lines 1-3 are used only for your EPIC determination.

	Your Yearly Income	Spouse's Yearly Income
1. Social Security and/or Railroad Retirement Benefits, (less Medicare Part B premiums) paid to you by check or direct deposit.	$	$
2. Other Income: Include Pensions, Annuities, Interest, Dividends, IRA Distributions, Capital Gains, Wages, Business Income or Losses, Net Rental Income, etc.	$	$
3. Total YEARLY Income (Add lines **1** and **2**)	$	$

(Please fill in pages 2 and 3)

EPIC has two plans:

FEE PLAN

Members pay an annual fee to EPIC based on their previous year's income (see chart to the right). Those with Full Extra Help from Medicare have their fee waived. Members will pay EPIC co-payments for Part D and EPIC covered drugs after the Part D deductible, if any, is met. Members will pay EPIC co-payments for Part D excluded drugs.

If you are single:

Annual income range	Annual fee range
$6,000 or less	$8
$6,001-$9,000	$16-$28
$9,001-$11,000	$36-$40
$11,001-$15,000	$46-$80
$15,001-$17,000	$110-$140
$17,001-$19,000	$170-$200
$19,001-$20,000	$230
Over $20,000	See Deductible Plan

If you are married:

Annual joint income	Annual fee per person
$6,000 or less	$8
$6,001-$10,000	$12-$24
$10,001-$13,000	$28-$36
$13,001-$15,000	$40
$15,001-$18,000	$84-$126
$18,001-$21,000	$150-$194
$21,001-$24,000	$216-$260
$24,001-$26,000	$275-$300
Over $26,000	See Deductible Plan

Under the fee plan EPIC pays the Part D monthly drug plan premiums up to the average cost of a basic Medicare drug plan ($38.90 per month in 2023).

"Extra Help" Determination: Report your total current monthly income.

EPIC will use your answers to lines 4-22 to apply for a federal benefit called "Extra Help" on your behalf. This is required by law to obtain EPIC benefits. If you already receive "Extra Help" benefits proceed to line 23 (skip lines 4-22) to indicate that you are providing a copy of your determination letter.

CURRENT MONTHLY AMOUNTS (Enter $0 if no income)	**Your Income**	**Spouse's Income**
4. Monthly Social Security before deductions	$	$
5. Monthly Railroad Retirement before deductions	$	$
6. Monthly Veterans Benefits before deductions	$	$
7. Monthly – Other pensions and annuities before deductions (not including any amount reported in the **Assets** section below)	$	$
8. Monthly – Other income not listed above (including alimony, net rental income, workers' compensation, private or state disability payments)	$	$
8A. Specify TYPE of other income (line 8):		
9. Total MONTHLY Income (Add lines **4-8**)	$	$

If your income exceeds the limit placed on "Extra Help" for the calendar year you are applying in (see EPIC's web site at http://health.ny.gov/health_care/epic/medicare.htm or the Social Security Administration web site at http://www.ssa.gov), please skip lines 10-22 then continue. If you do not have Internet access, call the EPIC Helpline at: 1-800-332-3742 (TTY 1-800-290-9138).

10. Have any amounts reported on lines **4-8** decreased during the last two years? ☐ Yes ☐ No

11. Bank accounts – total current balance (checking, savings, money market, certificates of deposit) $

12. Stocks, bonds, savings bonds, mutual funds Individual Retirement Accounts or other similar investments $

13. Cash at home or anywhere else $

14. Total Assets (Add lines **11-13**). $

If your assets exceed the limit placed on"Extra Help" for the calendar year you are applying in (see EPIC's web site at http://health.ny.gov/health_care/epic/medicare.htm or similar information at CMS's web site), please skip lines 15-22 and proceed with signing.

15. Will your assets be used for funeral or burial expenses? ☐ Yes ☐ No

16. Do you own real estate other than your home? ☐ Yes ☐ No

17. How many relatives living with you depend on you to provide at least one-half of their financial support? (do not include you or your spouse)

18. What do you expect to earn in wages before taxes and deductions this calendar year? You: $ Spouse: $

19. If self-employed, what are your expected net earnings or loss this calendar year? You: $ Spouse: $

20. Have the amounts reported for lines **18** or **19** decreased in the last two years? ☐ Yes ☐ No

21. If you recently stopped working or plan to stop working, enter the month and year (example: 09/2018) You: ___ ___ / 20 ___ ___ Spouse: ___ ___ / 20 ___ ___

(Please fill in page 3)

DEDUCTIBLE PLAN

Members **must** meet an annual out-of-pocket deductible based on their previous year's income (see chart to the right), after which they will pay EPIC co-payments for covered drugs. Drug costs in the Part D deductible phase cannot be applied to the EPIC deductible.

If you are single:

Annual income range	Deductible range
$20,001-$23,000*	$530-$580
$23,001-$28,000	$720-$840
$28,001-$36,000	$870-$1,260
$36,001-$44,000	$1,290-$1,500
$44,001-$52,000	$1,530-$1,740
$52,001-$60,000	$1,770-$1,980
$60,001-$68,000	$2,010-$2,220
$68,001-$75,000	$2,250-$2,430
Over $75,000	Not Eligible

If you are married:

Joint annual income range	Deductible per person
$26,001-$29,000*	$650-$700
$29,001-$40,000	$725-$1,170
$40,001-$50,000	$1,200-$1,715
$50,001-$60,000	$1,745-$2,015
$60,001-$70,000	$2,045-$2,315
$70,001-$80,000	$2,345-$2,615
$80,001-$90,000	$2,645-$2,915
$90,001-$100,000	$2,945-$3,215
Over $100,000	Not Eligible

* For deductible plan members with income up to $23,000 single and $29,000 married EPIC pays the monthly Part D drug plan premiums up to the average cost of a basic Part D drug plan. Members with higher incomes must pay their Part D premium each month. Their EPIC deductible will be lowered by the annual cost of a basic Part D plan (approximately $467 in 2023) to help them pay.

22. If your spouse is younger than 65 and is blind or disabled, do you or your spouse pay for things that enable your spouse to work? ☐ Yes ☐ No ☐ N/A

23. If you are already qualified for Medicare Savings Program and receiving "Extra Help" benefits, have you attached a copy of your determination letter? ☐ Yes ☐ No ☐ N/A

If someone assisted you in completing this form, please provide their name, address and phone number.

Print Name

Phone Number (including area code)
( )

Mailing Address

City/State/ZIP Code

Read carefully and sign below:

I certify that the information on this form is correct. I reside in New York State and am not currently receiving full Medicaid benefits. I know that I am required to give proof of my age, income, residency, Medicare status and Medicare Part D drug plan, if any. I also know that I am required to enroll in a Medicare Part D drug plan in order to be enrolled in EPIC. I understand that failure to provide identifying information necessary to enroll in a Part D plan, or the Medicare subsidy (Extra Help), if eligible, may result in termination of EPIC coverage. I consent to the exchange of all information necessary to verify my eligibility among and between EPIC, the Social Security Administration, Medicare, the NYS Medicaid Program, the NYS Tax Department, Medicare Part D drug plans, and any other necessary entities. In the event of duplicate or overpayment by EPIC, I assign to EPIC any drug benefits that I may be entitled to under any Part D or governmental plan. I authorize my health care providers to release to the EPIC program my medical information pertaining to prescriptions and/or diagnosis to be used for payment, audit or related health care operations.

You (and your spouse if living together) must sign below:

Your signature (legal representation)

Date

Spouse's signature (legal representation)

Date

Caution: If you are "Extra Help" eligible and do not either complete lines 4-22 or provide a copy of your Social Security Determination Letter, then your application will be considered incomplete.

Mail this completed form to: **EPIC**
P.O. Box 15018
Albany, NY 12212-5018
or Fax: (518) 452-3576

NEW YORK STATE
EPIC
Elderly Pharmaceutical Insurance Coverage Program

The information on this application is kept strictly confidential and is used only to determine your eligibility for EPIC as well as to apply for the federal benefit "Extra Help" on your behalf, as required by law.

To find out more information about the EPIC program or request a form in another language, please visit:
www.health.ny.gov/health_care/epic

Toll-free EPIC Helpline
1-800-332-3742
(TTY 1-800-290-9138)
8:00 a.m.–5 p.m.
Mon.–Fri.