

SOCIAL SECURITY AND MEDICARE

The following pages are information on Social Security and Medicare that was given out at the May 9, 2012 meeting. The guest speaker was John Sciacchitano, a volunteer from RSVP (Senior Retired Volunteer Program). He is a Medicare counselor and gives presentations at the Sachem library every month.

If you would like to contact him directly his cell # is 631-804-9039
If you are interested in RSVP, their contact info is at the end of the document.

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Your Social Security retiree benefit is based on your lifetime earnings. Social Security uses your average monthly earnings during the 35 years in which you earned the most. Your actual earnings are adjusted to account for changes in average wages since the year you earned them. A formula is applied to these earnings to arrive at your benefit at full retirement age. It is important to check your earnings record which will be provided by the Social Security Administration on request. Your record should show your earnings for all the years you have worked and paid SS taxes.¹

Earnings are the primary factor in computing your benefit but not the only one. The next most important factor is when you choose to begin receiving benefits.

You will receive full retirement benefits at a certain age based on the year you were born. You will receive a lesser benefit if you retire before your full retirement age. Choosing when to take your benefits is one of the most important decisions you will make.

If you elect to take your benefit as early as age 62 your benefit is reduced by approximately $\frac{1}{2}$ of 1% for each month you start receiving benefits before your full retirement age.

You may choose to delay receiving your retirement benefits past your full retirement age and your benefit amount will be increased until you start taking benefits or you reach age 70.

You may work and get Social Security retirement benefits at the same time, but keep in mind that while working beyond full retirement age can increase your benefits they will be reduced if your earnings exceed certain limits. Once you reach your full retirement age your earnings will have no effect on your retirement benefit.²

In general you may want to take your benefit early if:

- You are no longer working and can't make ends meet without your benefits
- You are in poor health and don't expect to make it to average life expectancy
- You are the lower-earning spouse and your higher-earning spouse can wait to file for a higher benefit.

You may not want to take your benefit early if:

- You are still working and make enough to significantly impact the taxability of your benefits. Wait until your normal retirement age so benefits aren't further reduced due to earnings.
- You are in good health and expect to exceed average life expectancy.
- You are the higher-earning spouse and want to be sure your surviving spouse receives the highest possible benefit.

Roughly 2/3 of Americans have decided to take their benefit before their full retirement age, but that choice may not be right for everyone Make an informed decision. You may want to consult with a financial advisor A widow or widower may receive reduced benefits as early as age 60 and full benefits at full retirement age.

A disabled widow or widower may receive benefits as early as age 50

A widow or widower at any age if he or she takes care of the deceased's child

who is under age 16 or disabled and receives Social Security benefits
Unmarried children under 18, or up to age 19 if they are attending high school full time.

Children at any age who were disabled before age 22 and remain disabled.

Dependent parents age 62 or older

Under certain circumstances, benefits can be paid to stepchildren, grandchildren, or adopted children.

Surviving spouses may begin receiving a deceased spouse's benefit and later switch to their own at the full rate when they reach full retirement age.

The rules for surviving spouses are complicated. Make an appointment for a sit-down

conference with a Social Security representative about all the options available to you. If you are receiving Social Security Disability benefits, those benefits will be converted to retirement benefits when you reach full retirement age. Nothing will change; for Social Security purposes your benefits will be called retirement benefits instead of disability benefits.

Medicare is the nation's largest health insurance program, currently covering about 44 million Americans. It is health insurance for people age 65 and older and for anyone who has been receiving the Social Security Disability benefit for 24 months and anyone, of any age with End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (Lou Gehrig's disease),³ Medicare is administered by The Centers for Medicare & Medicaid Services, a federal agency that runs Medicare, Medicaid, and the Children's Health Insurance Programs. If you are a citizen or permanent resident of the United States you are eligible to receive Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment, and you are at least 65 years old. Persons receiving Social Security Disability payments become eligible 24 months after being certified disabled.⁴

If you are already receiving Social Security benefits, the Social Security Administration will enroll you in Medicare automatically without an additional application. You should receive a "Welcome to Medicare" package, which will include your Medicare card about 3 months before age 65.⁵

For most people coverage will be effective the 1st of the month you turn 65.⁶
If you are 65 and receiving SS retirement benefits and do not receive your

Medicare card three months before your eligibility date -CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE

Persons who are receiving SS Disability benefits will be automatically enrolled and will be eligible when they have been certified disabled for 24 months. Benefits begin the 25th month of the disability.

If you are receiving Disability Benefits (for more than 24 months) and do not receive your Medicare card three months before your eligibility date CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE

You do not need to be retired, or be receiving Social Security retiree benefits to be enrolled in Medicare. If you are not already getting SS retirement benefits, you should contact SS about three months before your 65th birthday to sign up for Medicare. CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE

Sign up for Medicare even if you do not plan to retire at age 65. You must enroll during the 7 month period surrounding your 65th birthday.

This is called the Initial Enrollment Period which spans 3 months before your birthday month, your birthday month, and the 3 months after your birthday month. Medicare Part B is very valuable insurance. Failure to enroll or delaying enrollment in Part B (unless you are eligible for a Special enrollment Period) can have significant financial consequences.

Special Enrollment Period

You may be eligible for a SEP if: You or your spouse were working and had group health plan coverage through your employer or union; You or your spouse or family member is disabled. You enroll during the 8-month period that begins when employment or health insurance ends without a financial penalty, but you will avoid gaps in coverage and other complications if you sign up so that you are enrolled in Medicare as soon as your employer sponsored coverage ends. **COBRA is not considered employer sponsored coverage.**

Medicare Consists Of 4 Parts

Original Medicare includes Parts A and B. Parts C and D are part of Medicare BUT benefits are provided by private insurance companies. Parts C & D are subsidized by Medicare and are subject to standards and guidelines established by Medicare. Medicare benefits always require beneficiary participation in the forms of deductibles, coinsurance and or co-payments.

Part A

Part A provides coverage of inpatient hospital services including a semiprivate room, meals, general nursing, and other hospital services and supplies, skilled nursing facilities, home health services and hospice care. Most people do not have to pay a premium for Part A because the individual or their spouse paid Medicare taxes while working. If you do not meet the work requirements, it is possible to receive Part A coverage by paying a premium.⁸

Part A pays all costs for in-hospital medical services after a \$1,132 deductible for days 1 - 60:

You pay:

\$283 each day for days 61-90:

\$566 each day for days 91 - 150:

all costs beyond 150 days: you pay- BUT -

Original Medicare will pay for a total of 60 extra days — called "lifetime reserve days" — or when you are in a hospital more than 90 days during a benefit period.

At a Skilled nursing facility Medicare pays all skilled nursing services for the first 20 days

You pay:

\$141.50 per day for days 21-100 each benefit period

All costs for each day after day 100 in a benefit period

Part B

Part B pays for the cost of physician services, outpatient hospital services, medical equipment and supplies and other health services and supplies.

There is a \$115.20/month premium for part B that applies to single persons earning under \$85,000/year; and married couples earning under \$170,000/year. Persons making more than those limits will pay a higher Part B premium.⁹

In addition to the premium you pay the first \$162 yearly for Part B-covered services or items (annual deductible). After you have satisfied your deductible, Medicare pays 80% of the Medicare-approved amount for the covered service. Most doctors who treat patients with Medicare accept assignment, which means they agree to accept the Medicare-approved amount as payment in full. When you see a doctor who takes assignment, you are responsible for the coinsurance 20%.

Non-participating doctors, or doctors who don't routinely take assignment, can bill their Medicare patients up to 10 percent more (in NY State) than the Medicare-approved amount for most services and can request full payment up-front for services. Medicare will reimburse you for their obligation (80% of the Medicare- approved amount).

Providers who have opted out of Medicare can charge Medicare patients whatever they want. They must officially opt out. When you see a doctor who has opted out of Medicare, you pay the entire cost of your care (except in emergencies).

Part C

Part C is Managed Care Health Insurance called Medicare Advantage
Managed care is a system by which insurance companies attempt to reduce health care costs by participating in the medical decisions you make.

Managed care systems impose controls on the utilization of health care services or the providers who offer such care. Some rely on primary care physicians who acts as a gatekeeper through whom the patient has to go to obtain other health services such as specialists, surgical procedures or physical therapy.

If you enroll in a Medicare Advantage plan your benefits will be paid by the plan, NOT BY Medicare

Part C is a collection of managed care plans called Medicare Advantage Plans (MAP).

Medicare Advantage plans are sold and administered by private Medicare-approved insurance companies.

MA plans are subsidized by Medicare and replace Medicare Parts A & B. They may include

Part D insurance

You may (usually) be responsible for co-pays and deductibles.

MAPs often but not always, lower out-of-pocket costs. MA plans will often include prescription drug plan.

Keep in mind that your healthcare insurer will be the MA plan that you join, not Medicare. You will receive all benefits from your insurer. You will not use your Medicare card.

The main types of MAPS sold in this area are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs)
HMOs restrict your choices of doctors and facilities to their network, but often

provide the lowest out-of-pocket costs to you. The HMO will not pay anything if you go outside of their provider network.

Usually you will have to receive a referral from a primary care physician for referrals to a specialist.

HMOs decide how much they will pay for each service and then they contract with doctors and hospitals who agree to accept those payments.

You will have co pays and deductibles, but costs MAY be lower than with Original Medicare and are usually lower than with a PPO.

Persons who spend a significant part of the year in other states (typically, snowbirds) should consider that the benefits provided by HMOs out of your service area are usually restricted to medical emergencies.

PPOs offer savings when you use their network of doctors, but allow you to go out of their network if you are willing to make larger co-payments.

PPO subscribers have more choices than HMO subscriber; they do not need to have a primary care physician, request referrals or be restricted to the PPOs network of providers.

The PPO maintains a network of preferred doctors and facilities where out-of-pocket costs are standardized. Subscribers have the option of using doctors and hospitals that are not in the network.

However -

When a member chooses to use doctors or hospitals outside of the network, they will be responsible for the difference between what their PPO pays and what the provider charges.

This may amount to substantial co-pay and you may have to pay up front and wait for reimbursement from the PPO.

Part D

Part D Medicare Prescription Drug Plans are private insurance that you purchase from private insurance companies. You must be enrolled in Part A, Part B or both to be eligible to participate.

You should sign up when you first become eligible for Medicare - unless you have a creditable prescription drug plan where you work or from your former employer. You will incur a considerable penalty if and when you do sign up if you do not enroll when you first become Medicare eligible.

Premiums, deductibles, covered drugs and co-pays vary with plans, but Medicare has

established some basic rules. Each plan has its own formulary (a list of drugs it will cover).

If you join a Medicare prescription drug plan, you may have to pay an annual

deductible before coverage begins. The maximum plan deductible for 2011 range is \$310

During the initial coverage phase, you pay a co-payment, and your Part D drug plan pays its share for each covered drug until your combined amount, including your deductible, reaches \$2840.¹⁰ Once you and your Part D drug plan have spent \$2,840 for covered drugs, you will be in the coverage gap known as the "donut hole".

While in the gap you have to pay all costs out-of-pocket for your drugs.

Your yearly deductible, coinsurance or co-payments, and what you pay in the coverage gap all count toward this out-of-pocket limit.¹¹

The coverage gap continues until your total costs reach \$4,550. This annual out-of-pocket spending amount includes your yearly deductible, co-payment, and coinsurance amounts but does not include the drug plan's premium.

When your costs exceed \$4,550 out-of-pocket, the coverage gap ends and your drug plan pays most of the costs (95%) of your covered drugs for the remainder of the year. This is known as catastrophic coverage.

Part D prescription drug plans are neither good nor bad. They must be chosen using very specific criteria (namely the prescription drugs that you are taking on a regular basis).

There is a lot of help available from Medicare, State and local agencies and your pharmacist that can help you decide - take advantage of it. Avoid making decisions based on contacts by mail, phone or internet that come from insurance providers. They may not provide accurate or complete information.

Medigap-Supplementary Insurance

Medigaps are insurance policies sold by private companies that pay the portion of your

healthcare costs that Original Medicare does not cover, namely the Parts A and B deductibles and coinsurance. Medigap insurance is supplementary to Medicare. If you enroll in a Medigap policy, Medicare is your primary insurer and the Medigap will pay all or some (depending on the plan you choose) of the deductibles and coinsurance of Parts A & B.

The plans have standard benefits that are defined by Medicare. Coverage and options are easy to understand.¹²

Any provider that accepts Medicare will accept your Medigap insurance and it is not necessary to obtain a referral in order to see a specialist.

The premiums for Medigap can vary widely from insurer to insurer, but the coverage cannot.

Medigap providers are not permitted to combine their policies with

prescription drug insurance

You may obtain medical services from almost any doctor, hospital or other health care facility anywhere in the country.

The combination of Medicare and Medigap provides you and your doctor maximum control over treatment decisions.

Healthcare Options as a Medicare Beneficiary

Original Medicare

Original Medicare with a Part D Plan?

Original Medicare with a Medigap Plan and a Part D Plan

A Medicare Advantage Plan with a built-in Part D plan

A Medicare Advantage Plan and a stand-alone Part D plan

Original Medicare-

Advantages

You may obtain medical services from almost any doctor, hospital or other health care facility anywhere in the country.

There are limits on the amount doctors can charge you.

You and your doctor may have more control over treatment decisions than you will have with other methods.

Disadvantages

Deductibles and co-payments can add up quickly in the event of serious or complicated illness

Medicare Advantage (Part C Medicare) -

Advantages

Relatively inexpensive - premiums are low, MA plans are heavily subsidized by Medicare. May include extra benefits not included in Original Medicare.

You may be able to purchase a Medicare approved (creditable) Prescription Drug plan as an adjunct to your plan.

Medicare Advantage (Part C Medicare)

Disadvantages

You will lose some control over your choice of doctors and even courses of treatment. You usually must get the Primary Care Physician's permission or referral before seeing a specialist.

You may have difficulty locating providers and facilities that accept the plan you select

Generally, you are only covered for the care you get from providers that are in the HMO's "network."

While you are away from your service area (county), you only have coverage for emergency or urgently needed care.

HMO contracts are made and renewed with you and the government for a period of one calendar year.

HMOs may raise premiums, cut benefits or stop offering Medicare coverage

altogether with each new calendar year.

Some MA plans (PPOs)do not require you to use a Primary Care Physician and allow you to go to any doctor of facility, but your co-payments may be very high and you may have to pay in advance. PPOs can be difficult to manage.

Medigap

Advantages

All of the advantages of Original Medicare. You choose doctors hospitals and any medical service that accepts Medicare. You and your physician choose a course of treatment

Medigaps cover co-payments, coinsurance and deductibles in Original Medicare.

The plans are standardized and easy to understand.

Disadvantages

Premiums are very high

You will have to purchase a stand-alone Part D prescription drug plan

Ineligible for Medicare-No retiree benefits-There is help!

Healthy NY

The Healthy NY program is designed to assist small business owners in providing their employees and their employees' families, uninsured sole proprietors and workers whose employers do not provide health insurance. Other individuals may benefit from this valuable program - see specific events below.

Reduced-cost health insurance is available under the Healthy NY program.

In order to participate, you must meet the following eligibility criteria:

- You must reside in New York State.
- You or your spouse must either be currently employed or must have been employed within the past 12 months.
- Your employer does not currently provide you with health insurance.
- You have not had health insurance for twelve months prior to your Healthy NY

application or have lost that coverage due to a specific event. **Specific events include but are not limited to the following:**

- loss of employment
- death of a family member
- change to a new employer
- change of residence
- discontinuation of a group health plan
- termination or cancellation of COBRA coverage (if you are eligible for COBRA

coverage or have COBRA coverage, you can still apply for Healthy

NY)

- termination of participation in a public health insurance program, including Family Health Plus, Child Health Plus or Medicaid
- legal separation, divorce or annulment
- loss of eligibility for group health insurance coverage
- aging off of a parent's insurance policy
- You must be ineligible for Medicare.
- Your current gross (before taxes) household income meets the income guidelines of the program.

The website contains an easy to use eligibility scanner that can quickly help you to determine if you are eligible for this reduced-rate medical insurance. The savings are substantial.

Guidebooks and Applications

1-866-HEALTHY

1-866-432-5849

Hotline hours of operation are 8:00 a.m. through 5:00 p.m., Monday through Friday. www.HealthyNY.com

Family Health Plus and Child Health Plus

Family Health Plus is a public health insurance program run by the Department of Health for adults between the ages of 19 and 64 who do not have health insurance — either on their own or through their employers — but have incomes too high to qualify for Medicaid. Family Health Plus is available to single adults, couples without children, and parents with limited income who are residents of New York State and are United States citizens or fall under one of many immigration categories.

Family Health Plus provides comprehensive coverage, including prevention, primary care, hospitalization, prescriptions and other services. There are no costs to participate in Family Health Plus. Health care is provided through participating managed care plans in your area. To apply for Family Health Plus, you will need to have a personal interview where you will complete an application, provide proof of certain information, and select a health plan.

Enrollment facilitators are located near your home or work, to help you apply, ease the enrollment process and answer your questions. Please call 1-877-9FHPLUS (1-877-934-7587), and ask about Family Health Plus.

New York State also has a health insurance plan for kids, called Child Health Plus. Child Health Plus is run by the Department of Health. Depending on your family's income, your child may be eligible to join either Child Health Plus A (formerly Children's Medicaid) or Child Health Plus B. Both Child Health Plus A and B are available through dozens of providers throughout the state. Enrolling in Child Health Plus is easy.

To be eligible for either Child Health Plus A or B, children must be under the

age of 19 and be residents of New York State. Whether a child qualifies for Child Health Plus A or Child Health Plus B depends on gross family income. Children who are not eligible for Child Health Plus A can enroll in Child Health Plus B if they don't already have health insurance and are not eligible for coverage under the public employees' state health benefits plan. Please call this toll-free number: 1-800-698-4KIDS (1-800-698-4543), and ask about Child Health Plus.

NYP\$

NYP\$ is a free pharmacy discount card that is sponsored by New York State. You

can use this card at participating pharmacies to save as much as 60% on generics and 30% on brand name drug. The savings are provided through the cooperation and support of local pharmacies and drug manufacturers.

How to Apply for the NY Prescription Saver Card

To be eligible, each applicant must be:

- a resident of New York State;
- not receiving Medicaid;
- either (a) age 50 up to 65, or (b) determined disabled by the Social Security Administration

- have annual income under \$35,000 if single or \$50,000 if married.

Each person applying needs to fill out a separate application. If you have a spouse or another family member who is applying, they should complete a separate

application. Each applicant that is approved will receive his or her own pharmacy discount card,

or learn more and apply online at <http://nyprescriptionsaver.fhsc.com> or call them 1-800-788-6917 (TTY 1-800-290-9138)

Glossary

Medicare vocabulary words you should know.

A deductible is the amount you will pay, before Medicare or your insurer will begin to pay.

A limit is a maximum amount of money or services that Medicare or your insurer will pay for your healthcare.

The Initial Enrollment Period is the Medicare enrollment period for individuals as they turn age 65. This seven-month period starts three months

prior to the month of the individual's 65th birthday and continues three months following the month the individual turns 65 years of age. The individual's Medicare effective date depends on when the individual enrolls in Medicare within the Initial Enrollment Period.

A benefit period begins the day you go to a hospital or skilled nursing facility (SNF) and ends when you haven't received any hospital or skilled care in a Skilled Nursing Facility for 60 days in a row. If you go into a hospital or a Skilled Nursing Facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period.

Example: If you go into the hospital on June 1st and are treated and released on June 10th,

June 1st begins your benefit period. Under part A you have a deductible that must be met before Medicare pays, (more about that later). If you are rehospitalized before the end of the benefit period, 60 days or in the case of the example, July 30th, you will not be responsible to pay the deductible again.

A premium is a payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Service area A method of payment whereby a HMD will pay the provider its usual and

customary full amount. Services out of the service area may be paid at a reduced rate or not at all.

Primary care physician A doctor selected by the enrollee from those affiliated with the insurer to be the first physician contacted for any medical problem. The doctor acts as the patient's regular physician and coordinates any other care the patient needs, such as a visit to a specialist or hospitalization.

Creditable prescription drug plan is one that contains coverage that is expected to pay (on average) as much as the standard Medicare prescription drug coverage.

Coinsurance The amount you may be required to pay for services after you pay any plan deductibles. It is usually expressed as a percentage of the cost. It differs from a co-payment only in that a

Co-payment is an amount of money you will be responsible for after Medicare or your insurer pays their share. It is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 co-payment for a doctor's visit or prescription.

Special Enrollment period -You may enroll in Medicare Part B any time while you are covered under the group health plan based on current employment; or enroll in Medicare Part B during the eight-month period that begins following the last month your group health coverage ends, or following the month employment ends—whichever comes first.

Endnotes

¹ You can apply on line at <https://secure.ssa.gov/apps6z/iss/main.html> or request a form by calling 1-800- 772-1213 to request form SSA-7004

² If you work and start receiving benefits before full retirement age, \$1 in benefits will be deducted for each \$2 in earnings you have above \$14,160. In the year you reach your full retirement age, your benefits will be reduced \$1 for every \$3 you earn over \$37,680 until the month you reach full retirement age. Once you reach full retirement age, your Social Security benefit will not be reduced no matter how much you earn.

³ Social Security offers an online retirement application that you can complete in as little as 15 minutes, <http://www.ssa.gov/planners/about.htm>
Or (recommended) make a sit-down appointment with a Social Security representative at the local office. 1-800-772-1213

⁴ Special provisions are in place to allow early enrollment for persons with these conditions

⁵ Most beneficiaries will be eligible for Medicare on the first day of the month that they turn 65. Disabled persons will be eligible on the first day of the 25th month after they became eligible for Social Security disability

⁶ If your birthday falls on the first day of a month, you will be eligible for Medicare beginning the first day of the previous month

⁷ When you first become eligible for hospital insurance (Part A), you have a seven-month Initial Enrollment Period (IEP) in which to sign up for medical insurance (Part B).

If you are eligible at age 65, your initial enrollment period begins three months before your 65th birthday, the month you turn age 65 and three months after that birthday.

If you enroll at any time during that 7-month period, you will suffer no financial penalty BUT if you enroll at any time after the month before you are eligible your coverage will be delayed.

If you enroll in the month of your birthday, your Part B Medicare coverage starts

1 One month after you apply.

If you apply in the month after the month of your birthday, your Part B Medicare coverage starts two months after enrollment.

If you enroll in the second or third month after the month of your birthday, your Part B Medicare coverage starts 3 months after enrollment.

The same provisions apply when a beneficiary or spouse is working and qualifies for Special Enrollment Period (SEP).

⁸ The Part A premium is \$248.00 per month for people having 30-39 quarters of Medicare-covered employment. It is \$450.00 per month for people who have less than 30 quarters of Medicare-covered employment.

⁹ The part B premium is established by the Department of Health and Human **Services (HHS). It is based upon the cost of providing the Part B benefit. The**

Medicare Trust pays 75% of the cost and you, the beneficiary are responsible for 25%.

Persons earning more than the limits will pay more based upon tax returns from two years previous.

¹⁰

You pay 25% of the cost of drugs ¹¹ The Healthcare reform Act now provides that you get a 50% discount on covered brand-name prescription medications while in the donut hole. [New in 2011]

¹² Medigap plans are supplemental insurance policies may purchase to help pay some of the costs you have to pay if you have Original Medicare. If you don't have retiree insurance from or through a former employer, you might want to think about getting a Medigap.

There are 10 different Medigap plans you can buy. Medigap policies are standardized and classified by letters A, B, C, D, F, G, K, L, M and N. Each plan letter signifies a group of benefits no matter which insurance company you get the plan from.

All plans called Medigap cover the hospital copayment which is the amount you must pay each day during an inpatient hospital stay. All plans also pay for 365 additional hospital days after Original Medicare ends.

In addition all pay part or all of the coinsurance for Part B covered service which is what you pay for outpatient services such as doctor visits, x-rays and lab tests (20% of the Medicare allowable amount). They also pay hospice

Note that there are high deductible plans (Hi-deductible F and K-N, that have deductibles and differ in other ways than as described above.

Some plans also cover the:

Part B annual deductible (\$162 in 2011)

Part A Hospital deductible (\$1,132 for each stay in 2011)

Skilled nursing facility coinsurance

Part B excess charges

Emergency care outside of the United States

All the plans are available to Suffolk residents, but not all companies sell all the plans.

RSVP is the most complete volunteer resource in Suffolk County
RSVP has the answers and the opportunities for Suffolk County residents' age 55 and older who wish to remain active and vital through service in their community.
Our 900+ volunteers are essential helpers in Hospitals, Museums, Schools, Childcare Centers, Adult Homes, Nursing Homes, Emergency Service Providers, Food Pantries and at other community service organizations throughout Suffolk County.
Our volunteers provide comfort to shut-ins, computers for seniors and via the Speaker's Bureau, a source of pertinent information untainted by commercial interest.
RSVP knows where the need is and matches your interests, abilities and schedule to those needs.

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East Enders can call our

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(6312) 288 - 0754

or our

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or visit our website at

<http://www.rsvpsuffolk.Org/>

