



Medicare Retiree Premium & Benefit Assistance Programs

Medicare Plan Year 2017 January 1, 2017 through December 31, 2017

This application is for premium and benefit assistance beginning January 1, 2017. We are collecting this information now because it's tax time and you should have all of the necessary information at hand.

PEIA offers premium and benefit assistance to retired employees and surviving dependents who qualify. Assistance is based on the years of service of the policyholder. Here are the two components:

1. **Premium assistance:** reduces the monthly premium payment for the retiree or surviving dependent. Premium assistance is available to Medicare retirees with at least 5 years of service.
2. **Benefit assistance:** reduces the medical and prescription drug out-of-pocket costs for retirees with Medicare and at least 15 years of public service.

Premium Assistance:

The premium assistance program pays part of your health insurance premium if your gross income is less than 250% of Federal Poverty Level. To qualify for premium assistance you must meet **all** of the following criteria:

- you must have 5 or more years of service,
- you must be enrolled in the Humana/PEIA Plan 1 or the PEIA Special Medicare Plan, and
- your household income during calendar year 2015 must have been at or below 250% of the Federal Poverty Level (FPL).

Premium AND Benefit Assistance:

To qualify for premium **and** benefit assistance you must meet all of the following criteria:

- Medicare must be your primary insurance,
- you must have 15 or more years of service,
- you must be enrolled in the Humana/PEIA Plan 1 or the Special Medicare Plan, and
- your household income during calendar year 2015 must have been at or below 250% of the Federal Poverty Level (FPL).

Below is a chart with the income guidelines and corresponding poverty level. Find the number of people in your household, then look across the chart to find your total annual household income. The gray box above your income will tell you your percentage of the federal poverty level, and that will determine the amount of assistance you may receive.

Federal Poverty Level				
Individuals in Household	<100%	100%-150%	150%-200%	200% - 250%
1	\$11,880 or less	\$11,881 – 17,820	\$17,821 – 23,760	\$23,761– 29,700
2	\$16,020 or less	\$16,021 – 24,030	\$24,031 – 32,040	\$32,041 – 40,050
3	\$20,160 or less	\$20,161 – 30,240	\$30,241 – 40,320	\$40,321 – 50,400
4	\$24,300 or less	\$24,301 – 36,450	\$36,451 – 48,600	\$48,601 – 60,750
Each additional person add	\$4,160	\$6,240	\$8,320	\$10,400

Premium Assistance

Find your poverty level and your years of service in the chart below. This will show you the dollar amount of the premium reduction for which you are eligible. For example, if you have 20 years of service, your income is \$16,500 and you are the only individual in your household, then your poverty level is 100% - 150%. In the chart below, go to the column labeled "100-150% of FPL" and the row labeled 15 – 24. You are eligible for a monthly premium reduction of \$50.

Policyholder Only Monthly Premium Reduction

This amount will be deducted from your monthly premium for Medicare or non-Medicare coverage. If the amount of the reduction is greater than the premium, then the premium due will be \$0.

Years of Service	<100% of FPL	100-150% of FPL	150-200% of FPL	200 – 250% of FPL
5-14	\$51	\$34	\$19	\$13
15-24	\$65	\$50	\$31	\$19
25+	\$88	\$74	\$46	\$24

Policyholder with Dependents Monthly Premium Reduction

This amount will be deducted from your monthly premium for Medicare or non-Medicare coverage. If the amount of the reduction is greater than the premium due, then the premium due will be \$0.

Years of Service	<100% of FPL	100-150% of FPL	150-200% of FPL	200 – 250% of FPL
5-14	\$76.50	\$51.00	\$28.50	\$19.50
15-24	\$97.50	\$75.00	\$46.50	\$28.50
25+	\$132.00	\$111.00	\$69.00	\$36.00

Benefit Assistance

In addition to premium assistance, **Medicare retirees with 15 or more years of service** receive benefit assistance. Benefit assistance is only provided if Medicare is the primary insurer. Out-of-pocket costs for members with benefit assistance will be as follows :

For Plan Year 2017 (January 1 – December 31, 2017) Copays are for 30-day supply unless otherwise noted.	Humana/PEIA Plan 1 Benefit (With Benefit Assistance)	PEIA Special Medicare Plan (With Benefit Assistance)
Medical Benefits		
Medical Deductible	\$25	\$25
Medical out of pocket maximum	\$300	\$300
Office visit copayment	\$2	\$2
Specialist office visit copayment	\$5	\$5
Prescription Drug Benefits		
Generic	\$3	\$3
Generic (90-day supply) mail order or retail maintenance network	\$6	\$6
Preferred Brand	\$10	\$10
Preferred Brand (90-day supply) mail order or retail maintenance network	\$20	\$20
Non-preferred Brand*	\$50	75% coinsurance
Non-preferred Brand (90-day supply) mail order or retail maintenance network*	\$100	n/a
Preferred Specialty Medication	\$50	\$50
Non-preferred Specialty Medication	\$50	\$100
Prescription Out-of-Pocket Maximum	\$250	\$250

Sick and Annual Leave or Years of Service Credits

If you are using sick or annual leave or years of service credits to get free or reduced premiums, **please do not fill out this form -- unless** you will run out of credits before December 31, 2017. If your credits will run out before December 31, 2017, you may apply now. If your application is approved, premium assistance will begin when your credits end.

Deadline for Applications

If you want your assistance to begin on January 1, 2017, we must receive your application before November 7, 2016. The applications will be processed in the order received. You may apply for assistance at any time during the year, but if we receive your application after November 7, 2016, we will process it as quickly as possible and, if you qualify, your premium and benefit reductions will be effective the first day of the month following the date of your approval. PEIA will not issue credit for previous months' premiums. You will receive a letter informing you of the approval or denial of your application.

**STATE OF WEST VIRGINIA
PUBLIC EMPLOYEES INSURANCE AGENCY
PLAN YEAR 2017
MEDICARE RETIRED EMPLOYEES PREMIUM & BENEFIT ASSISTANCE PROGRAM
- APPLICATION FORM -**

PLEASE PRINT OR TYPE

SECTION I - RETIREE/SURVIVING DEPENDENT

Name (First, Middle Initial, Last)	Social Security Number
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Address (If New Address Check Box)

City	State	Zip	County
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Phone Number (including Area Code) ()	Marital Status (Check One) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed
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Years of Service at the Time of Retirement

SECTION II - SPOUSE & HOUSEHOLD INFORMATION

Spouse Name (First, Middle Initial, Last)	Spouse Social Security Number
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How Many Individuals on your PEIA insurance? Circle one - 1 2 3 4 5 6 7	How Many Individual Live In Your Household Circle one - 1 2 3 4 5 6 7
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SECTION III - GROSS ANNUAL INCOME FOR 2015

	List Your Income Below	List Spouse's Income Below	List Income of Other Dependents Below
State Pension	\$	\$	\$
Other Pension (If any)	\$	\$	\$
Social Security	\$	\$	\$
Wages (If any)	\$	\$	\$
Other Income	\$	\$	\$
Subtotal	\$	\$	\$

Total Gross Household Income for 2015 (include your income, income for your spouse and all other dependents that live in your household) \$

To avoid delays in processing, you must send proof of all income for 2015 with this application. It will NOT be processed without supporting documentation.

I understand that if, as a result of withholding information or providing inaccurate information, I receive assistance to which I am not entitled, such assistance will be subject to recovery by PEIA and I may be subject to legal action. I declare that I have examined my responses and, to the best of my knowledge, believe they are true, correct and complete.

Your Signature

Date

MAIL COMPLETED FORM TO:	FOR PEIA USE ONLY:
PEIA Retiree Assistance Program 601 57 th St., SE, Suite 2 Charleston, WV 25304-2345 OR Fax to 1-877-233-4295	Approved: _____ Disapproved: _____ Effective Date: _____ Number in Household: _____

PLAN YEAR 2017 PREMIUM ASSISTANCE PROGRAM APPLICATION INSTRUCTIONS

Please read all instructions carefully BEFORE completing the application.

SECTION I - RETIREE/SURVIVING DEPENDENT

- **Name** – Use your full name, including middle initial.
- **Social Security Number (SSN)** – Fill in the correct SSN or we cannot process your application.
- **Address** – Provide your complete mailing address. (If address has changed, please check the box on the address line so we may update our records.)
- **Phone Number** (include area code).
- **Marital Status** – please check appropriate box. If separated, please check married.
- **Years of Service at the Time of Retirement/Retirement Date** – Applications without this information cannot be processed. Surviving Dependents must report the Years of Service of the deceased policyholder. If the policyholder was retired at the time of death, report years of service and retirement date. If death occurred while an active employee, then give years of service and the month and year of death.

SECTION II – SPOUSE INFORMATION

If **married**, you must complete spouse's name and Social Security number. Also, indicate the number of individuals covered on your PEIA insurance and the number of individuals living in your household.

SECTION III – GROSS ANNUAL INCOME FOR 2015

This section must include All Household Income from 2015, before any deductions. Everyone in the household who has an income must report that information on the application.

Income: Complete the sections that apply to you.

- **State Pension*** – Yearly amount you and the members of your household (if applicable) receive from the WV Consolidated Public Retirement Board.
- **Other Pension*** – Yearly amount of pensions you and the members of your household (if applicable) receive from other sources (Example: TIAA/CREF).
- **Social Security*** – Yearly amount for you and the members of your household
- **Wages*** – Total amount of any income earned during 2015 for you and the members of your household.
- **Other Income*** – Total amount of any other income received during 2015, for all members of your household (Example: Rent, Dividends, Royalties, Interest, Alimony, etc.).
- **Subtotal** – Total each column.
- **Grand Total** – All subtotal amounts.

* **Include spouse and any other members of your household, if applicable.**

THIS APPLICATION MUST BE SIGNED AND DATED! Applications without a signature and date will be returned without processing.

ATTACHMENTS

- If you have copies of W2s, 1099s or any official year-end statements, you must attach these to verify your income.
- If you file taxes, a copy of your 2015 Federal tax return (first page) is acceptable. All income must be reported on the tax return.
- If you file taxes and your Social Security benefit amount is not on the form, then you must provide a copy of your SSA-1099.

SUBMITTING YOUR APPLICATION

Please separate the Application Form and submit only the application to PEIA (address is on the application).