Section 8
Health Care Coverage
Importance of Health Insurance

By Healthcare.gov

Most people need medical care to stay healthy throughout their lives.

Health insurance covers medical care and protects against expensive medical costs.

The Affordable Care Act of 2010 made many changes to health insurance coverage. Each state has a health insurance marketplace where that state’s residents can examine coverage options and apply for health insurance. There are subsidies to help pay the cost of health insurance coverage for many people. Beginning in 2019, people are not required to have health insurance coverage and will not have to pay a penalty if they are uninsured.

The Affordable Care Act changed health insurance and the benefits that insurance companies must cover. You get free preventive care like vaccines, screenings, and some check-ups. Insurance companies cannot refuse to cover you. They cannot refuse necessary treatment. They cannot charge you more if you have a preexisting condition like pregnancy, a chronic health condition or mental or behavioral health issues.

Health insurance now covers the following essential benefits to help you stay healthy and treat your illnesses and accidents.

**Essential health benefits:**

- Emergency services.
- Outpatient care you get without being admitted to a hospital.
- Hospital care like surgery and overnight stays.
- Pregnancy, maternity and newborn care before and after birth. Coverage begins the day your health insurance starts.
- Mental health and substance abuse including counseling and psychotherapy.
- Prescription drugs.
- Rehabilitative and habilitative services and devices. These services help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services for children including oral and vision care.

There are many different types of health insurance. Choosing the right health insurance for you depends on what you and your family need.

Disclaimer: The Caregiver Consortium has used the most recent information for the Resource Guide. Please check with your insurance company to ensure that you are receiving the benefits you deserve.

*Source: www.healthcare.gov/why-coverage-is-important/coverage-protects-you/*
Types of Health Insurance

Compiled by the Caregiver Consortium

Health Insurance Marketplace
The Health Insurance Marketplace, or "Exchange," offers standardized health insurance plans to individuals, families and small businesses. People to age 65, and those over 65 without Medicare, are eligible for coverage.

The Health Insurance Marketplace provides health plan shopping and enrollment services through websites, call centers, and in-person help. The federal government operates the Marketplace online, at HealthCare.gov, for Arizona and most states. Other states run their own Marketplaces.

Small businesses can use the Small Business Health Options Program (SHOP) Marketplace to provide health insurance for their employees.

You will provide income and household information when you apply for individual and family coverage through the Marketplace,. You will find out if you qualify for:

- Premium tax credits and other savings and subsidies that make insurance more affordable
- Coverage through the Arizona Health Care Containment System, Arizona’s Medicaid program, and the Children’s Health Insurance Program (CHIP).

Source: www.CMS.gov

Employee-Sponsored Health Plan
Of Americans who have health coverage, nearly 60 percent secure that coverage through an employer-sponsored plan, often called group health insurance. Millions take advantage of the coverage for reasons as obvious as employer responsibility for a significant portion of the health care expenses. Group health plans are also guaranteed issue, meaning that a carrier must cover all applicants whose employment qualifies them for coverage. In addition, employer-sponsored plans typically are able to include a range of plan options from HMO and PPO plan to additional coverage such as dental, life, short- and long-term disability.

Source: https://www.healthinsurance.org/glossary/employer-sponsored-health-insurance/

Employer-sponsored health insurance is paid for by businesses on behalf of their employees as part of an employee benefit package. Most private (non-government) health coverage in the US is employment-based. Nearly all large employers in America offer group health insurance to their employees.

Generally, employers subsidize the cost of the insurance, but workers share the expense through a variety of payments, including premiums, co-payments and deductibles.

Medicare
Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease [permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD].

Original Medicare is coverage managed by the federal government rather than an insurance company. Generally, there's a cost for each service you receive.

The different parts of Medicare help cover specific services:

• Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
• Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.
• Part C, called a Medicare Advantage Plan, is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations [HMOs], Preferred Provider Organizations [PPOs], Private Fee-for-Service Plans [PFFS], Special Needs Plans [SNPs], and Medicare Medical Savings Account Plans [MMSAs]. If you enroll in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren’t paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.
• Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Source: www.medicare.gov

Other Government-Sponsored Programs
Medicaid is a jointly funded, Federal-State health insurance program for people who are eligible due to income and medical need. Arizona Health Care Cost Containment System [AHCCCS] is Arizona’s Medicaid program. AHCCCS covers children, people who are aged, blind, and/or people with disabilities. Some other people are eligible if they receive federally assisted income maintenance payments. Some adults have eligibility through Medicaid expansion under the Affordable Care Act of 2010 [ACA].

CHIP is the Children’s Health Insurance Program. CHIP provides low-cost health coverage to children in families that earn too much money to qualify for AHCCCS [Medicaid]. Your children may be eligible for CHIP if they are not insured already. If they qualify, you won’t have to buy an insurance plan to cover them.

Source: www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/
VA and TRICARE
TRICARE is the health care program for uniformed service members and their families. TRICARE includes active duty and retired members of the: U.S. Army, U.S. Air Force, U.S. Navy, U.S. Marine Corps, U.S. Coast Guard, the Commissioned Corps of the U.S. Public Health Service and the Commissioned Corps of the National Oceanic and Atmospheric Association.

TRICARE provides comprehensive coverage through a variety of different plans to meet individual and family need. Coverage includes health plans, prescriptions, dental, and special programs.

Most TRICARE health plans meet the requirements for minimum essential coverage under the Affordable Care Act of 2010.

Source: www.tricare.mil/About

Private Insurance Market
Private insurance is insurance provided by a private health insurance company. Health insurance that is provided through state or federal governments is not private insurance.

Private insurance includes health insurance purchased through insurance brokers, health insurance marketplaces, or as employer-sponsored health plans.

Source: https://www.healthinsurance.org/glossary/private-health-insurance/
<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>Who is Eligible</th>
<th>Where to Enroll</th>
<th>When to Enroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance</td>
<td>Everyone from newborn to 65&lt;br&gt;65 and over, not enrolled in Medicare</td>
<td>Depends on the type of Marketplace&lt;br&gt;Federally-facilitated or Partnership – Enroll through HealthCare.gov or the Marketplace Call Center at 1-800-318-2596, TTY: 1-855-889-4325&lt;br&gt;State based – State’s Marketplace website and the state’s Marketplace Call Center&lt;br&gt;All – agents and brokers</td>
<td>Marketplace Open Enrollment: November 15, 2014 – February 15, 2015&lt;br&gt;Special Enrollment Period (if you qualify)&lt;br&gt;Any time for Medicaid and CHIP</td>
</tr>
<tr>
<td>Employer–Sponsored Health Plan&lt;br&gt;(includes Small Business Health Options Program or SHOP)</td>
<td>People who are actively employed, and their spouse/dependents&lt;br&gt;Retirees</td>
<td>With your employer&lt;br&gt;HealthCare.gov starting November 15 if your employer participates in SHOP</td>
<td>At the time you’re hired (there may be a waiting period)&lt;br&gt;When you have a life changing event (marriage, birth or adoption of child, etc)</td>
</tr>
<tr>
<td>Medicare</td>
<td>People who are 65 and older&lt;br&gt;People of any age who have End-Stage Renal Disease&lt;br&gt;People under 65 with certain disabilities and entitled to Social Security Disability Insurance</td>
<td>With Social Security (SocialSecurity.gov), if not automatically enrolled&lt;br&gt;With the Railroad Retirement Board (RBB.gov), if not automatically enrolled (for railroad retirees)</td>
<td>Medicare Initial Enrollment Period&lt;br&gt;Medicare Special Enrollment Period&lt;br&gt;Medicare General Enrollment Period</td>
</tr>
<tr>
<td>Medicaid and CHIP&lt;br&gt;(other Government- Sponsored Programs)</td>
<td>People who have been determined eligible for these programs</td>
<td>With the state or federal agency&lt;br&gt;Health Insurance Marketplace</td>
<td>Apply anytime</td>
</tr>
<tr>
<td>VA and TRICARE</td>
<td>Veterans and their families, depending on the service members’ discharge from active military service, their active duty status or retiree status</td>
<td>With your military employer&lt;br&gt;Apply online at VA.gov/HEALTHBENEFITS/Apply, or at your local VA health care facility</td>
<td>At the time you enlist or are commissioned as a Department of Defense employee&lt;br&gt;When you receive your military separation or retirement orders</td>
</tr>
<tr>
<td>Private Insurance Market</td>
<td>Everyone from newborn to 65&lt;br&gt;65 and over, not enrolled in Medicare</td>
<td>With private insurance companies&lt;br&gt;Agents and brokers</td>
<td>Open Enrollment Period&lt;br&gt;Special Enrollment Period&lt;br&gt;Any time depending on the company</td>
</tr>
</tbody>
</table>


DISCLAIMER: This isn’t a legal document, but is provided as a quick reference. It’s not comprehensive. Official program provisions are contained in the relevant statutes, regulations, and rulings. For more information visit Medicare.gov, HealthCare.gov, SocialSecurity.gov, VA.gov, TRICARE.mil, or your State Medical Assistance Office.
What is Medicare?

By Pima Council on Aging and the Pima County State Health Insurance Program (SHIP)

Medicare is health insurance for:
- People 65 or older
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

What are the different parts of Medicare?

Medicare Part A (Hospital Insurance) helps cover:
- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. This is sometimes called premium-free Part A. If you aren't eligible for premium-free Part A, you may be able to buy Part A, and pay a premium.

Medicare Part B (Medical Insurance) helps cover:
- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment
- Some preventive services

Most people pay the standard monthly Part B premium.

Note: You may want to get coverage that fills gaps in Original Medicare coverage. You can choose to buy a Medicare Supplement Insurance (Medigap) policy from a private company.

Medicare Part C (Medicare Advantage):
- Run by Medicare-approved private insurance companies
- Includes all benefits and services covered under Part A and Part B
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- Usually includes extra benefits and services, in some cases for an extra cost
Medicare Part D (Medicare prescription drug coverage):

- Run by Medicare-approved private insurance companies
- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future.

Note: If you have limited income and resources, you may qualify for help to pay for some health care and prescription drug costs. For more information, contact your State Medical Assistance (Medicaid) office, visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you have questions about Medicare, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Contact Pima Council on Aging for a no-cost health insurance benefits counseling service for Medicare beneficiaries, caregivers and their families in Pima County that provides easy-to-understand information about Medicare coverage and financial assistance programs. Medicare counselors are trained in Medicare eligibility, benefits and options, health insurance counseling and related insurance products. The program is not connected to any insurance company so you can be sure you are getting accurate and objective information to help you make decisions about Medicare coverage. Call the Medicare line at (520) 546-2011 or email ship@pcoa.org.

Medigap

Medigap is the name of Medicare Supplement Insurance. To be eligible to buy a Medigap plan, you must have both Medicare Part A and Part B. A Medigap policy only covers one person. It does not cover spouses or other family members.

Medigap policies are sold by private companies. You can buy a Medigap policy from any insurance company that's licensed in Arizona to sell one. You will pay an additional monthly fee for your Medigap coverage. You will also pay the monthly premium that you pay to Medicare for your Part B coverage.

Medigap policies can help pay some of the health care costs that Original Medicare doesn’t cover. Common costs covered are copayments, coinsurance, and deductibles.

Some Medigap policies also offer coverage for services that Original Medicare doesn’t cover like medical care when you travel outside the U.S.

Medigap policies don’t cover everything. Medigap policies generally don't cover long-term care, vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Medigap policies cannot include prescription drug coverage. You must enroll in Medicare prescription drug coverage through Medicare Part D or Part C.

Any standardized Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company cannot cancel your Medigap policy as long as you pay the premium.

A Medigap policy is different from a Medicare Advantage Plan. A Medicare Advantage Plans is a way to get Medicare benefits. A Medigap policy only supplements your Original Medicare benefits. If you wish to switch from a Medicare Advantage Plan to a Medigap plan, you must make sure you can leave the Medicare Advantage Plan before your Medigap policy begins.

When you buy a Medigap policy to supplement Original Medicare, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share of the remainder.

Source: www.medicare.gov/supplement-other-insurance/medigap/
Arizona Health Care Cost Containment System (AHCCCS)

Compiled by the Caregiver Consortium

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program. AHCCCS provides health insurance to low income Arizonans through a health plan. Doctors, hospitals, pharmacies, etc., are included in the health plan to provide all AHCCCS covered services.

In addition to health plans, AHCCCS has several programs for seniors including:

- Medicare Cost Sharing: provides help with Medicare expenses
- SSI Cash/Medical Assistance Only: provides medical coverage for seniors who do not receive monthly cash benefits under the Supplemental Security Income Program (SSI)
- Arizona Long Term Care System (ALTCS) which provides long-term care services for individuals who require nursing home level of care, either at an individual’s home, assisted living facility or in a nursing home.

Medical services

AHCCCS contracts with several health plans to provide covered services. An AHCCCS health plan works like a Health Maintenance Organization (HMO). The health plan works with doctors, hospitals, pharmacies, specialists, etc., to provide care. You will choose a health plan that covers your zip code area. If you are approved, you will choose a primary care doctor that works with that health plan. Your primary doctor will:

- Be the first person you go to for care
- Authorize your non-emergency medical services
- Send you to a specialist when needed

AHCCCS health plans provide the following medical services:

- Doctor's Visits
- Immunizations (shots)
- Prescriptions (Not covered if you have Medicare)
- Lab and X-rays
- Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services for Medicaid eligible children under age 21
- Specialist Care
- Hospital Services
- Transportation to doctor
- Emergency Care
- Podiatry Services Performed by a Podiatrist
• Pregnancy Care
• Surgery Services
• Physical Exams
• Behavioral Health
• Family Planning Services
• Glasses (for children under age 21)
• Dialysis
• Vision Exams (for children under age 21)
• Dental Screening (for children under age 21)
• Dental Treatment (for children under age 21)
• Hearing Aids (for children under age 21)
• Hearing Exams (for children under age 21)

Coverage for individuals eligible for Arizona Long Term Care (ALTCS)
AHCCCS contracts with several program contractors to provide long term care services. An ALTCS program contractor works like a Health Maintenance Organization (HMO). The program contractor works with doctors, nursing homes, assisted living facilities, hospitals, pharmacies, specialists, etc., to provide care. In addition to the services listed above, people who qualify for long term care can receive services such as:
• Nursing Facility
• Hospice
• Attendant Care
• Assisted Living Facility
• Adult Day Care Health Services
• Home Health Services, such as nursing services, home health aide, and therapy
• Home Delivered Meals
• Case Management

Source: Compiled from information on the AHCCCS website: www.azahcccs.gov.
State Health Insurance Program

By PCOA and the Pima County
State Health Insurance Program (SHIP)

The Arizona State Health Insurance Assistance Program (SHIP) is a no-cost, one-on-one, personal health benefits counseling program for Medicare beneficiaries and their families or caregivers. Medicare counselors can explain your options, assist you in comparing plans and help you understand how Medicare works with other insurance plans. Trained staff and volunteers provide unbiased information and can help with:

- Medicare eligibility and benefits
- Original Medicare
- Medigap insurance
- Medicare Advantage Plans
- Understanding and enrolling in Medicare Part D
- Long Term Care Insurance
- Medicare and AHCCCS

Understanding Medicare workshops are offered once a month.

The SHIP is an independent program funded by the Administration for Community Living and the Centers for Medicare and Medicaid Services and is not affiliated with the insurance industry.

The Senior Medicare Patrol (SMP) is a SHIP program that empowers seniors to prevent health care fraud. Health care fraud, waste, and abuse cost American taxpayers nearly $60 billion each year. This program recruits and trains retired professionals and other older adults who provide presentations about how to:

- Identify potential scams and other fraudulent activity
- Protect personal information including Medicare and Social Security numbers
- Detect errors on Medicare Summary Notices (MSN's) or Explanations of Benefits (EOB's)
- Report suspected fraud or abuse to the proper authorities

For assistance with Medicare, to attend a workshop, to request a presentation, or to learn more about SMP, call the Medicare Line at Pima Council on Aging at (520) 546-2011.

Source: Pima County SHIP, Pima Council on Aging; www.pcoa.org.
Many pharmaceutical companies offer assistance programs that provide medications at reduced or no cost to patients in financial need. There are also charitable organizations and foundations that provide assistance to patients who need financial help to obtain prescription medications or treatment. Financial help is not available for all medications, conditions or treatments.

Most programs are limited to helping pay for specific drugs that treat specific medical conditions and will not help with medications that treat side effects such as nausea.

The following organizations will locate patient assistance programs for you. You can use their databases to search by drug name, pharmaceutical company or diagnosis. You can also search for prescription discount cards, manufacturer drug coupons and other sources of help. There is no cost to use these services.

**What You Will Need**

Be prepared to provide information and answer questions. Information you might want to have on hand:

- The name of your condition or disease (diagnosis).
- Your doctor’s name and phone number.
- What treatments you are receiving or need (dialysis, radiation, etc.).
- Your insurance or Medicare number (if applicable).
- Your monthly income from all sources.
- Your living expenses (rent, utilities, car payment, food, etc.).
- Your medical expenses (co-payment amounts, co-insurance amounts, and the amount of your annual deductible).

You will also want to make a list of all your prescription medications, including:

- The name of the drug (Spiriva®, Depakote®, SINGULAIR®, etc.).
- The name of the company that makes the drug (Pfizer, Merck, Novartis, etc.). To find the drug company name, look on the drug label or ask your pharmacist.
- The dosage (1 X per day, 2 X per day, etc.).
- The strength (25 mg, 100 mg, etc.).

**NeedyMeds**  
(800) 503-6897  
www.needymeds.org

**Rx Assist**  
Web-based help only.  
www.rxassist.org

**Partnership for Prescription Assistance**  
Web-based help only.  
www.pparx.org

**Rx Hope**  
Web-based help only.  
www.rxhope.com
Simplified Guide to ALTCS
Arizona Long Term Care System

ALTCS is a part of AHCCCS—Arizona’s version of Medicaid

ALTCS provides funding for:
- Care in a person’s home
- Care in contracted nursing homes
- Care in contracted assisted living centers, assisted living homes, and adult foster care homes

General Eligibility Requirements
- Must be U.S. Citizen or have Legal Resident Status for a required period
- Must have a valid Social Security Number
- Must reside in Arizona

Medical Eligibility
Each applicant is assessed for medical eligibility using a tool called the Pre-Admission Screening (PAS). To be eligible, the individual must need a level of care equal to what is provided at an intermediate level nursing facility.

This usually includes a need for assistance with bathing, toileting, and dressing. Applicants are assessed by social workers or nurses who review medical records, conduct face to face interviews, and assess the applicant’s ability to perform activities of daily living.

Generally, a family member or responsible party should be present at the interview to provide input. Applicants often try to show the assessor how well they are doing, while what is needed for eligibility is to show how incapacitated they really are. Applicants may not tell a stranger they are incontinent of bowel or bladder even if they are, and incontinence scores high on the PAS. Also, a diagnosis of Alzheimer’s or other forms of dementia gives extra consideration for eligibility.

Income Eligibility
Individuals: Gross Income may not exceed $2,250/month.
Married Couples: If the income in the applicant’s own name is less than $2,250, he or she will be income eligible. Otherwise, the couple’s joint income may not exceed $4,500/month.

Note: If income is greater than the limits above but less than the “Average Cost of Care” ($7,134/month) the applicant may be able to set up a special “Income Limiting Trust” and be eligible. The trust must make the State of Arizona the beneficiary upon death and meet specific guidelines. (We recommend you consult with an Elder Law Attorney for this trust.)

The spouse remaining in the community may keep all income in his or her name. If the community spouse’s income is less than $2,057/month, then he or she may be able to keep a portion of the institutional spouse’s income for a total monthly income of $2,057.

Share of Cost
If the member is living in a facility, he or she is expected to pay a share of the cost to the facility.

For an individual the share of cost is equal to their income, less $112.50 they can keep as a “Personal Needs Allowance.”

For a couple it is the individual’s income less the $112.50 less the amount the community spouse is allowed by ALTCS regulation.

To Apply: Call ALTCS at (520) 205-8600
**Resource (Asset) Eligibility**
The state includes all assets (including most trusts) except:
- Equity value of home up to $552,000 (Arizona residence with intent to return even if the intent is not realistic).
- One car (for use in getting to medical care).
- Burial plots (for applicant or spouse or immediate family).
- Burial funds limited to $1,500 (simple separate account will do or ask the funeral home about an ALTCS qualifying plan).
- Life insurance if total cash value of all redeemable policies is less than $1,500.
- Household goods, including jewelry, furniture, pets, tools, etc.
- Special needs trusts meeting ALTCS requirements.

**For Individuals:** Non-excluded resources may not exceed $2,000.

**For a Couple:** If only one spouse needs care, the following rules apply:
The spouse remaining in the community can keep all the exclusions listed for the individual plus the federally mandated allowance under “Spousal Impoverishment” guidelines. This means that if the couple’s countable resources are:
- Less than $24,720, the community spouse may keep the total resource.
- Over the $24,720, subject to a resource assessment.
- Maximum Community Spouse Resource Deduction $123,600. (See AHCCCS Public Information Brochure “Community Spouse Overview.”)

**If both spouses require care,** the joint non-excluded resources may not exceed $3,000.

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**Transfer of Property for Less than Value**

**WARNING** If you give away or transfer funds or property for less than market value within 5 years (60 months) of applying for ALTCS, that transfer may make you ineligible. The penalty may be calculated at a rate of one month ineligibility for every $7,134 (the “Average Cost of Care”) that has been transferred. Federal laws have gotten more restrictive in the past few years and gifts or payments to families are carefully scrutinized.

**Estate Recovery**
In Arizona, the state may file a claim for reimbursement against the estate of an individual who received services through ALTCS for what the state calculates as the value of those services. This recovery is no longer limited to the Probate Estate of the recipient of services. Therefore, property that does not go through probate, such as property held in joint tenancy with right of survivorship, may be subject to recovery. Arizona will not seek to recover from an estate if there is: a surviving spouse, and/or a child under age 21, and/or a blind or totally disabled child. (See “ALTCS Long Term Care Medical Assistance Estate Recovery Program Brochure.”) As with all government regulations, Estate Recovery may change.

**For help:** If you need help or assistance with understanding ALTCS or have been denied coverage you believe you are entitled to receive please call **PCOA's Help Line at (520) 790-7262.**

**PCOA holds a class on ALTCS** the 2nd Thursday of each month at 2:00 P.M. at our office located at 8467 E. Broadway, Tucson, AZ. There is no cost to attend.

For more information or to register, please call Pima Council on Aging at **(520) 790-7262.**

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To Apply: Call ALTCS at (520) 205-8600
ALTCS POLICIES ON COMMUNITY SPOUSE

When a person who applies for ALTCS has a legally married spouse who is living at home or anywhere other than a medical facility, we call the spouse of the applicant the community spouse. We use special rules called community spouse rules. Community spouse rules allow the community spouse to keep some of the couple’s resources for the community spouse’s own needs. Other rules may allow the community spouse to receive part of the applicant spouse’s income.

**How much of the couple’s countable resources does the community spouse get to keep?**
The resource limit for the ALTCS program is $2,000. When we use community spouse rules, a portion of the couple’s resources can be set aside for the needs of the community spouse and is not counted towards this limit. The amount of resources that can be kept by the community spouse is called the Community Spouse Resource Deduction (CSRD).

The community spouse’s personal CSRD will be calculated by an ALTCS Eligibility Specialist when a resource assessment is completed.

Resources that are counted include:
- cash;
- checking and savings account balances;
- stocks;
- bonds;
- certificates of deposit;
- treasury bills;
- cash surrender values for life insurance policies;
- cash surrender values for annuities;
- available assets in a trust;
- additional vehicles (other than the one listed below); and
- real property (other than your home in Arizona).

Resources that are not counted include:
- your home property in Arizona (unless held in a trust);
- one vehicle per household for transportation;
- burial plots;
- irrevocable burial plans; and
- household goods and personal effects.

**How is the CSRD calculated?**
1. We total all of the countable resources owned by both spouses (singly or jointly) as of the first month one spouse was “institutionalized”. “Institutionalized means being in a medical facility for 30 consecutive days or more, or receiving paid home and community based services such as attendant care, which include services like hands-on assistance with activities of daily living, (for example: mobility, transferring, toileting).
2. We divide the countable resources owned by both spouses in half to determine the “spousal share”.
3. The “spousal share” is compared to the minimum and the maximum CSRD amount.
   - If the “spousal share” is less than $24,720 (effective January 2018), the CSRD amount will be $24,720.
   - If the “spousal share” is more than $123,600 (effective January 2018), the CSRD amount will be $123,600
   - If the “spousal share” is more than $24,720 and less than $123,600, then the amount that was calculated as the “spousal share” will be the community spouse’s CSRD.

How are resources calculated at the time of ALTCS application?
1. We total all of the countable resources owned by both spouses as of the application month.
2. We subtract the CSRD amount from the total countable resources.
3. We compare the remaining amount to the $2,000 ALTCS resource limit. The remaining amount must be less than or equal to the ALTCS resource limit for the applicant to be eligible.

How are resources calculated after ALTCS approval?
After the first twelve months of eligibility, all resources owned by the ALTCS member must be less than or equal to the $2,000 resource limit. Therefore, countable resources that are in the member’s name that are more than the resource limit must be transferred to the spouse during the 12 month period.

WARNING: If any of the ALTCS customer or spouse’s resources are transferred to anyone other than the spouse, the ALTCS customer may be ineligible for long term care for a period of time.

How is income eligibility determined?
When we use Community Spouse rules, income that is counted toward the $2,250 income limit (effective January 2018) may be counted in either of two ways:

1. The countable income of both spouses is added together and then divided by two (2). We compare that amount to the $2,250 monthly income limit.
2. If one half of the couple’s combined income exceeds the limit, only the applicant’s income is compared to the income limit.

If income still exceeds the limit, eligibility may still be established by setting up an Income Only (Miller) trust when the customer is in an appropriate living arrangement and has income that is less than the average private pay rate for Nursing Home Care. All other eligibility requirements must be met.

How much of the applicant’s income does the Community Spouse get to keep?
A spouse is allowed a minimum monthly need of $2,030 (effective July 1, 2017). An additional amount can be added if actual shelter costs are more than that amount. If the community spouse’s income is less than the total amount, then the spouse can keep some of the applicant’s income.

Please contact your local ALTCS office for additional information.

DE-817 (Rev 12/17)
Income Only Trusts (ALTCS)

By Pima Council on Aging

If an individual is otherwise eligible for the Arizona Long Term Care System (ALTCS), but his or her income is above the eligibility limit, an Income Only Trust, also known as a Miller Trust or Income Gap Trust, may help.

To qualify for an Income Only Trust in Arizona, an individual’s gross income must be:

1. Greater than $2,250/month (this is the monthly eligibility limit for ALTCS in 2018)
2. Less than $7,134.44/month (this is the current average private pay cost of care in Arizona).

Federal Regulations require the state to recognize a special income only trust.

How it works:

- The trust begins with a zero balance.
- All or part of the applicant/recipient’s income goes into the trust.
- Each month, the trust pays a Share of Cost to the facility equal to the individual’s income:
  - Minus $112.50 (personal needs allowance)
  - Minus medical premiums
  - Minus spousal needs allowance (if applicable)
  - (The balance is applied to the cost of care, in effect leaving a zero or close to zero balance.)
- If the trust is properly set up, the individual will be deemed eligible for Medicaid (ALTCS) services.
- The trust will be payable on death to the Arizona Health Care Cost Containment System (AHCCS).

Historically, the State of Arizona has resisted making these trusts easy to use. Therefore, PCOA recommends hiring an attorney knowledgeable in Medicaid eligibility to prepare these trusts. Southern Arizona Legal Aid does not provide help with Income Only Trusts because, to qualify for this type of trust, an individual’s income must be higher than their eligibility limits.

Long-Term Care

Complied by the Caregiver Consortium

Long-term care is personal and custodial care provided in a variety of settings. You can receive services at home, in a community setting such as adult daycare, and in assisted living and skilled nursing facilities. Long-term care is usually provided for an extended period of time.

Most long-term care isn’t medical care. Long-term care helps with basic personal tasks of everyday life. These are called activities of daily living or ADLs.

ADLs are things we normally do for ourselves. Things like bathing, grooming, dressing, eating, transferring from one area to another, and using the bathroom (or incontinence personal care) are ADLs.

Instrumental activities of daily living [IADLs] are necessary tasks for people to live independently. Housekeeping services, cooking and cleanup, shopping, and taking medication are all IADLs. People who are not able to be alone safely may need supervision.

Medicare does not cover the cost of long-term care.

Many people use their retirement savings to pay for their long-term care.

You may purchase private long-term care insurance when you are younger to help cover the cost of long-term care later.

The Arizona Long Term Care System (ALTCS) pays for long-term care for people who meet medical and financial eligibility requirements. People in ALTCS must need a level of care that is equal to the care received in a nursing facility. They may receive services at home, in a community setting, or in assisted living or skilled nursing facility.

Families provide most of the long-term care in Arizona.
Long-Term Care Insurance

Compiled by the Caregiver Consortium

Unlike traditional health insurance, long-term care insurance helps pay for long-term care services and support you need where you need them. Long-term care insurance covers personal and custodial care in a variety of settings. You can receive services at home, in a community setting such as adult daycare, and in assisted living and skilled nursing facilities.

Long-term care insurance has many levels of coverage. The cost of a long-term care insurance policy is based on the following:

- How old you are when you buy the policy
- The maximum amount your policy will pay for each day
- The maximum number of days or years that your policy will pay optional benefits you choose to receive
- A lifetime maximum amount that your policy will pay

Long-term care insurance reimburses a daily amount up to the policy’s pre-selected limit.

Long-term care insurance pays for help with personal care activities called activities of daily living [ADLs]. ADLs are things we normally do for ourselves. Things like bathing, grooming, dressing, eating, transferring from one area to another, and using the bathroom, (or incontinence personal care) are ADLs.

Long-term care insurance may also cover the cost of instrumental activities of daily living [IADLs]. IADLs are necessary for people to live independently. Housekeeping services, cooking and cleanup, shopping, and taking medication are all IADLs. Some policies may cover supervision for people who cannot be left alone.

Before you buy a policy, be aware that the insurance company may raise the premium cost on your policy in the future. It is a good idea to request information on the company’s premium rate history.

Source: https://longtermcare.acl.gov/costs-how-to-pay/what-is-long-term-care-insurance/
Health Insurance Marketplace

By CMS.gov

The Health Insurance Marketplace, or "Exchange," offers standardized health insurance plans to individuals, families and small businesses. People to age 65, and those over 65 without Medicare, are eligible for coverage.

The Health Insurance Marketplace provides health plan shopping and enrollment services through websites, call centers, and in-person help. The federal government operates the Marketplace online, at HealthCare.gov, for Arizona and most states. Other states run their own Marketplaces.

Small businesses can use the Small Business Health Options Program (SHOP) Marketplace to provide health insurance for their employees.

You will provide income and household information when you apply for individual and family coverage through the Marketplace.

You will find out if you qualify for:

- Premium tax credits and other savings and subsidies that make insurance more affordable
- Coverage through the Arizona Health Care Containment System, Arizona’s Medicaid program, and the Children’s Health Insurance Program (CHIP).

Source: www.CMS.gov
Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

**Allowed Amount**
Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

**Appeal**
A request for your health insurer or **plan** to review a decision or a **grievance** again.

**Balance Billing**
When a **provider** bills you for the difference between the provider’s charge and the **allowed amount**. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may **not** balance bill you for covered services.

**Co-insurance**
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan’s** allowed amount for an office visit is $100 and you’ve met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

**Complications of Pregnancy**
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren’t complications of pregnancy.

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<thead>
<tr>
<th>Co-payment</th>
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<tbody>
<tr>
<td>A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.</td>
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<tr>
<th>Deductible</th>
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<tr>
<td>The amount you owe for health care services your <strong>health insurance</strong> or <strong>plan</strong> covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.</td>
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<tr>
<th>Durable Medical Equipment (DME)</th>
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<tr>
<td>Equipment and supplies ordered by a health care <strong>provider</strong> for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.</td>
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<tr>
<th>Emergency Medical Condition</th>
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<tr>
<td>An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.</td>
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<th>Emergency Medical Transportation</th>
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<tr>
<td>Ambulance services for an <strong>emergency medical condition</strong>.</td>
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<th>Emergency Room Care</th>
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<td><strong>Emergency services</strong> you get in an <strong>emergency room</strong>.</td>
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<th>Emergency Services</th>
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<tr>
<td>Evaluation of an <strong>emergency medical condition</strong> and treatment to keep the condition from getting worse.</td>
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Excluded Services
Health care services that your health insurance or plan doesn’t pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn’t require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or other health care your health insurance or plan doesn’t cover. Some health insurance or plans don’t count all of your co-payments, deductibles, out-of-pocket payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.
Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
How You and Your Insurer Share Costs - Example

January 1st
Beginning of Coverage Period

Jane has not reached her $1,500 deductible yet
Her plan doesn’t pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane’s Plan Deductible: $1,500
Co-insurance: 20%
Out-of-Pocket Limit: $5,000

Jane pays 100% Her plan pays 0%

more costs

Jane reaches her $1,500 deductible, co-insurance begins
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs

Jane pays 20% Her plan pays 80%

more costs

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $200
Jane pays: $0
Her plan pays: $200

Jane pays 0% Her plan pays 100%
Social Security and Supplemental Security (SSI) Income Overview

By the Social Security Administration

To be eligible for Social Security benefits as a worker you must be:

- Age 62 or older, or disabled or blind
- “Insured” by having enough work credits

For applications filed December 1, 1996, or later, you must either be a U.S. citizen or lawfully present alien in order to receive monthly social security benefits.

How much work do you need to be “insured?”

We measure work in “work credits.” You can earn up to four work credits per year based on your annual earnings. The amount of earnings required for a work credit increases each year as general wage levels rise.

To be eligible for most types of benefits (such as benefits based on blindness or retirement), you must have earned an average of one work credit for each calendar year between age 21 and the year in which you reach age 62 or become disabled or blind, up to a maximum of 40 credits. A minimum of six work credits is required, regardless of age.

To qualify for Social Security benefits based on a disability other than blindness, the number of work credits you need for disability benefits depends on your age when you became disabled. You generally need 20 work credits earned in the last 10 years ending with the year you became disabled. However, younger worked may qualify with fewer credits.

The rules are as follows:

Before age 24 – You may qualify if you have six work credits earned in the three-year period ending when your disability starts.

Age 24 to 31 – You may qualify if you have credit for having worked half the time between age 21 and the time you become disabled. Example: If at age 27 you become disabled, you would need 12 work credits in the past six years (between age 21 and age 27).

Age 31 and older – You must have earned at least 20 of the credits in the 10 years immediately before you become disabled.

Who can receive benefits on your earnings?

You can receive social security benefits based on your earnings record if you are age 62 or older, or disabled or blind have enough work credits.

Family members who qualify for benefits on your work record do not need work credits. However, if they file an application December 1, 1996 or later, they must be a U.S. citizen
or lawfully present alien. The following information describes family members who may qualify for benefits on your work record.

**If you are receiving retirement or disability benefits, your spouse may qualify if he or she is:**

- Age 62 and over; or
- Divorced from you, age 62 or older, and was married to you for at least 10 years prior to your divorce; or
- Under age 62 and caring for a child (under age 16 or disabled prior to age 22) who is entitled to benefits on your work records.
- If you are age 62 and over and have enough work credits to receive Social Security benefits, but have not filed a claim, your divorced spouse may qualify for benefits, if he or she was married to you for at least 10 years prior to the divorce, and has been finally divorced from you for at least two years.

**Your surviving spouse (widow or widower) may qualify if he or she is:**

- Age 60 or older; or
- Age 50 or older and disabled; or
- Divorced from you, age 60 or older (age 50 if disabled) and
- Was married to you for at least 10 years prior to your divorce;
- Under age 60 and caring for your child (under age 16 or disabled prior to age 22) and who is entitled to child’s benefits’
- Divorced from you, under age 60 and caring for his or her child (under age 16 or disabled prior to age 22) who is entitled to benefits on your record.

**Others who may qualify:**

- A dependent parent(s), age 62 or older, of a deceased worker may qualify for benefits based on the worker’s record.
- Unmarried children (including stepchildren, adopted children and, in some cases, grandchildren and children work out of wedlock) of disabled, retired, or deceased workers may qualify if they are:
- Under age 18 (or between ages 18 and 19 if a full time high school student); or
- Age 18 or older and disabled before age 22.

**What is SSI?**

SSI stands for Supplemental Security Income. Social Security administers this program. We pay monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children may also get SSI.

**How is SSI different from Social Security benefits?**

Many people who are eligible for SSI may also be entitled to Social Security benefits. In fact, the application for SSI is also an application for Social Security benefits. However, SSI and Social Security are different in many ways.
• Social Security benefits may be paid to you and certain members of your family if you are “insured” meaning you worked long enough and paid Social Security taxes. Unlike Social Security benefits, SSI benefits are not based on your prior work or a family member’s prior work.

• SSI is financed by general funds of the U.S. Treasury—personal income taxes, corporate and other taxes. Social Security taxes collected under the Federal Insurance Contributions Act (FICA) or the Self-Employment Contributions Act (SECA) do not fund the SSI program.

• In most States, SSI beneficiaries also can get medical assistance (Medicaid)- to pay for hospital stays, doctor bills, prescription drugs, and other health costs.

• Many States also provide a supplemental payment to certain SSI beneficiaries.

• SSI beneficiaries may also be eligible for food assistance in every State except California. In some States, an application for SSI also serves as an application for food assistance.

• SSI benefits are paid on the first of the month.

• To get SSI, you must be disabled, blind, or at least 65 years old and have "limited" income and resources.

• In addition, to get SSI, you must also:
  o reside in the United States or the Northern Mariana Islands;
  o not be absent from the country for a full calendar month or more or for 30 consecutive days or more; and
  o be either a U.S. citizen or national, or in one of certain categories of qualified non–citizens.

How is SSI like Social Security Benefits?

• Both programs pay monthly benefits.

• The medical standards for disability are generally the same in both programs for individuals age 18 or older. For children from birth to age 18 there is a separate definition of disability under SSI. The medical standard is based on the severity of your disability and financial need is not considered at this step in the eligibility process.

• SSA administers both programs.

Source: Social Security Administration. See www.ssa.gov for more information.