# City of New York Health Benefits Program
## 2015 IRMAA Medicare Part B
## Reimbursement Claim Instructions

Federal law mandates that some beneficiaries pay a higher premium for Medicare Part B coverage based on their income. If you and/or your eligible dependent paid a Medicare Part B income-related monthly adjustment amount (IRMAA) during **CALENDAR YEAR 2015** - ***which means more than the standard Medicare Part B monthly premium during 2015*** - you may be entitled to an additional reimbursement (surcharge for late enrollment does not qualify as an amount that is eligible for additional reimbursement).

To claim the additional reimbursement you are required to document the eligible amount paid in excess of the standard premium. Please submit the following documentation as requested below:

### *Required Documentation*

**You MUST submit BOTH items indicated below to receive a reimbursement.**
(See sample documentation forms that follow)

Submit a copy of your and/or your eligible dependent's Social Security Administration (SSA) letter issued to you and/or your eligible dependent at the end of CALENDAR YEAR 2014 showing what the income-related monthly adjustment amount will be in CALENDAR YEAR 2015**.**

AND

Submit a copy of your and/or your eligible dependent's Form SSA-1099 issued to you by the SSA in January of CALENDAR YEAR 2016, as proof of the monthly Medicare Part B premium actually paid for CALENDAR YEAR 2015. *If you cannot provide a Form SSA-1099 because you did not receive Social Security benefits in 2015 you must provide official documentation that you paid Medicare premiums in 2015 (a receipt from Social Security, cancelled checks for Medicare premium payment, or similar official documentation).*

***YOU MUST INCLUDE THE RETIREE'S NAME AND FULL SOCIAL SECURITY NUMBER ON ANY ELIGIBLE DEPENDENT'S DOCUMENTS.***

If you need a replacement copy of your IRMAA letter you can obtain one from your local Social Security office, which can be located on the following website: www.socialsecurity.gov/onlineservices. This website can also be accessed to request a copy of the SSA-1099.

Submit **copies of both** of the documents listed above **for each eligible person,** along with a completed Submission Form, to:

City of New York, Office of Labor Relations
Health Benefits Program
40 Rector Street, 3rd Floor
New York, NY 10006
**Attention: IRMAA**

**2015 IRMAA reimbursement will be issued beginning in JUNE 2017.**

**(Claims that do not include both documents for each eligible person and claims that include documents for years other than the years specified above WILL NOT BE EVALUATED.)**

# City of New York Health Benefits Program
# 2015 IRMAA Medicare Part B
# Reimbursement Claim Submission Form

## Section 1. RETIREE INFORMATION:

**NAME:** _____
**LAST** **FIRST** **MI**

**ADDRESS:** _____
**NUMBER** **STREET** **APT**

_____
**CITY** **STATE** **ZIP**

**SOCIAL SECURITY NUMBER:** _____

## Section 2. DEPENDENT INFORMATION:

**NAME:** _____
**LAST** **FIRST** **MI**

**SOCIAL SECURITY NUMBER:** _____

## Section 3. REQUIRED DOCUMENTS

**3. A.** The following documents are included for retiree:

_____ Copy of Social Security Administration (SSA) letter stating your **2015** Medicare Part B premium plus your income related adjustment amount (IRMAA)

_____ Copy of **2015** Form SSA-1099 **OR** proof of direct payment (must provide proof of all payments for 2015)

**3. B.** The following documents are included for eligible dependent:

_____ Copy of Social Security Administration (SSA) letter stating your **2015** Medicare Part B premium plus your income related adjustment amount (IRMAA)

_____ Copy of **2015** Form SSA-1099 **OR** proof of direct payment (must provide proof of all payments for 2015)

**PLEASE DO NOT STAPLE OR TAPE THE SUBMITTED DOCUMENTS AS ALL DOCUMENTS WILL BE SCANNED**

*CLAIMS THAT DO NOT INCLUDE BOTH DOCUMENTS FOR EACH ELIGIBLE PERSON AND CLAIMS THAT INCLUDE DOCUMENTS FOR YEARS OTHER THAN THE YEAR SPECIFIED ABOVE WILL NOT BE EVALUATED*

****2015 IRMAA reimbursement will be issued beginning in JUNE 2017****

# Social Security Administration

Date: November 26, 20XX
Claim Number: XXXX-XX-XXX

City N.Y. Retiree
123 Your Home Street
New York, NY 1111-1111

Your Social Security benefits will increase by XX percent in 20XX because of a rise in the cost of living. The premium you pay for Medicare Part B (Medical Insurance) will increase because a Medicare law required some people to pay a higher premium for their Medicare Part B coverage based on their income.

The information in this notice about your premium is for one year only.

How Much Social Security Will I Get?

- Your new 20XX monthly benefit amount before deduction is: $ XX,XXX.XX
- Your 20XX deduction for Medicate Part B premium is: $ XXX.XX
  - $ XX.XX for the standard Medicare premium, plus
  - $ XXX.XX for the income related monthly adjusted amount based on your 20XX income tax return
- Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January XX, 20XX is: $ X,XXX.XX

Your Medicare Part B Premium

Your Medicare Part B premium for 20XX is the standard Medicare premium, plus any surcharges for late enrollment or re-enrollment, plus an income-related adjusted amount.

# FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT

**20XX** • PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME.
• SEE THE REVERSE FOR MORE INFORMATION.

| Box 1. Name | Box 2. Beneficiary's Social Security Number |
|---|---|

| Box 3. Benefits Paid in 20XX | Box 4. Benefits Repaid to SSA in 20XX | Box 5. Net Benefits for 20XX *(Box 3 minus Box 4)* |
|---|---|---|
| | | |

**DESCRIPTION OF AMOUNT IN BOX 3**

**Paid by check or direct deposit Medicare Part B premiums deducted from your benefits**
**Total Additions**
**Benefits for 20XX**

**DESCRIPTION OF AMOUNT IN BOX 4**

Box 6. Voluntary Federal Income Tax Withheld

Box 7. Address

Box 8. Claim Number *(Use this number if you need to contact SSA.)*

Form **SSA-1099-SM** (1-20XX)

**DO NOT RETURN THIS FORM TO SSA OR IRS**