

# EPIC

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

For more information on the 2025 EPIC program, visit [health.ny.gov/health\\_care/epic/member\\_info/program\\_highlights\\_2025.htm](http://health.ny.gov/health_care/epic/member_info/program_highlights_2025.htm) or call 1-800-332-3742 (TTY 1-800-290-9138).

## Eligibility

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

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

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



## EPIC and Medicare Part D

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

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

## EPIC Copayments

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

Courtesy of:



Assemblyman  
**Doug Smith**

### District Office:

4155 Veterans Memorial Highway, Suite 9  
Ronkonkoma, NY 11779  
631-585-0230

### Albany Office:

Room 318, LOB  
Albany, NY 12248  
518-455-5937

### Email:

[smithd@nyassembly.gov](mailto:smithd@nyassembly.gov)

[www.nyassembly.gov](http://www.nyassembly.gov)



# Application

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

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

|                                                           |  |       |                |                 |                                                                                          |                                                                                          |  |
|-----------------------------------------------------------|--|-------|----------------|-----------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--|
| Your Last Name                                            |  |       | First          | Middle Initial  | Social Security Number                                                                   |                                                                                          |  |
|                                                           |  |       |                |                 | _ _ _ _ _ _ _ _                                                                          |                                                                                          |  |
| c/o Name (if different from above)                        |  |       |                |                 |                                                                                          | Sex                                                                                      |  |
|                                                           |  |       |                |                 |                                                                                          | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X |  |
| Address Where You Live (not P.O. Box)                     |  |       |                |                 |                                                                                          | Your Date of Birth                                                                       |  |
|                                                           |  |       |                |                 |                                                                                          | Month / Day / Year                                                                       |  |
| City                                                      |  |       | State          | ZIP Code        | Your Telephone Number                                                                    |                                                                                          |  |
|                                                           |  |       |                |                 |                                                                                          | Area Code Number                                                                         |  |
|                                                           |  |       |                |                 |                                                                                          | ( )                                                                                      |  |
| Address Where You Get Your Mail (if different from above) |  |       |                |                 |                                                                                          | Marital Status                                                                           |  |
|                                                           |  |       |                |                 |                                                                                          | <input type="checkbox"/> Widowed, Single or Divorced                                     |  |
|                                                           |  |       |                |                 |                                                                                          | <input type="checkbox"/> Married, Living Together                                        |  |
|                                                           |  |       |                |                 |                                                                                          | <input type="checkbox"/> Married, Living Separately                                      |  |
| Spouse's Name (If Living)                                 |  |       |                |                 | Spouse's Social Security Number                                                          |                                                                                          |  |
| Last Name                                                 |  | First | Middle Initial |                 |                                                                                          |                                                                                          |  |
|                                                           |  |       |                | _ _ _ _ _ _ _ _ |                                                                                          |                                                                                          |  |
| Spouse's Telephone Number                                 |  |       |                |                 | Spouse's Date of Birth                                                                   |                                                                                          |  |
| Area Code Number                                          |  |       |                |                 | Month / Day / Year                                                                       |                                                                                          |  |
| ( )                                                       |  |       |                |                 |                                                                                          |                                                                                          |  |
|                                                           |  |       |                |                 | Spouse's Sex                                                                             |                                                                                          |  |
|                                                           |  |       |                |                 | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X |                                                                                          |  |

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

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

If you already have EPIC, enter your EPIC Identification Number \_\_\_\_\_

If your spouse has EPIC, enter your Spouse's EPIC Identification Number \_\_\_\_\_

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

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

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

## EPIC has two plans:

### FEE PLAN

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

#### If you are single:

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

#### If you are married:

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

Under the fee plan EPIC pays the Part D monthly drug plan premiums up to the average cost of a basic Medicare drug plan (\$72.34 per month in 2025).

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

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

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

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

|                                                                                                            |                                                          |
|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 10. Have any amounts reported on lines 4-8 decreased during the last two years?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Bank accounts – total current balance (checking, savings, money market, certificates of deposit)       | \$ _____                                                 |
| 12. Stocks, bonds, savings bonds, mutual funds Individual Retirement Accounts or other similar investments | \$ _____                                                 |
| 13. Cash at home or anywhere else                                                                          | \$ _____                                                 |
| 14. Total Assets (Add lines 11-13).                                                                        | \$ _____                                                 |

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

|                                                                                                                                                   |                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 15. Will your assets be used for funeral or burial expenses?                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Do you own real estate other than your home?                                                                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. How many relatives living with you depend on you to provide at least one-half of their financial support? (do not include you or your spouse) | _____                                                    |
| 18. What do you expect to earn in wages before taxes and deductions this calendar year?                                                           | You: \$ _____<br>Spouse: \$ _____                        |
| 19. If self-employed, what are your expected net earnings or loss this calendar year?                                                             | You: \$ _____<br>Spouse: \$ _____                        |
| 20. Have the amounts reported for lines 18 or 19 decreased in the last two years?                                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. If you recently stopped working or plan to stop working, enter the month and year (example: 09/2018)                                          | You: ____ / 20 ____<br>Spouse: ____ / 20 ____            |



DEDUCTIBLE PLAN

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

If you are single:

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

If you are married:

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

\* For deductible plan members with income up to \$23,000 single and \$29,000 married EPIC pays the monthly Part D drug plan premiums up to the average cost of a basic Part D drug plan. Members with higher incomes must pay their Part D premium each month. Their EPIC deductible will be lowered by the annual cost of a basic Part D plan (approximately \$868 in 2025) to help them pay.

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

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

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

Print Name

Phone Number (including area code)  
(       )

Mailing Address

City/State/ZIP Code

Read carefully and sign below:

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

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

Your signature (legal representation)

Date

Spouse’s signature (legal representation)

Date

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

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



EPIC  
Elderly Pharmaceutical  
Insurance Coverage  
Program

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

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