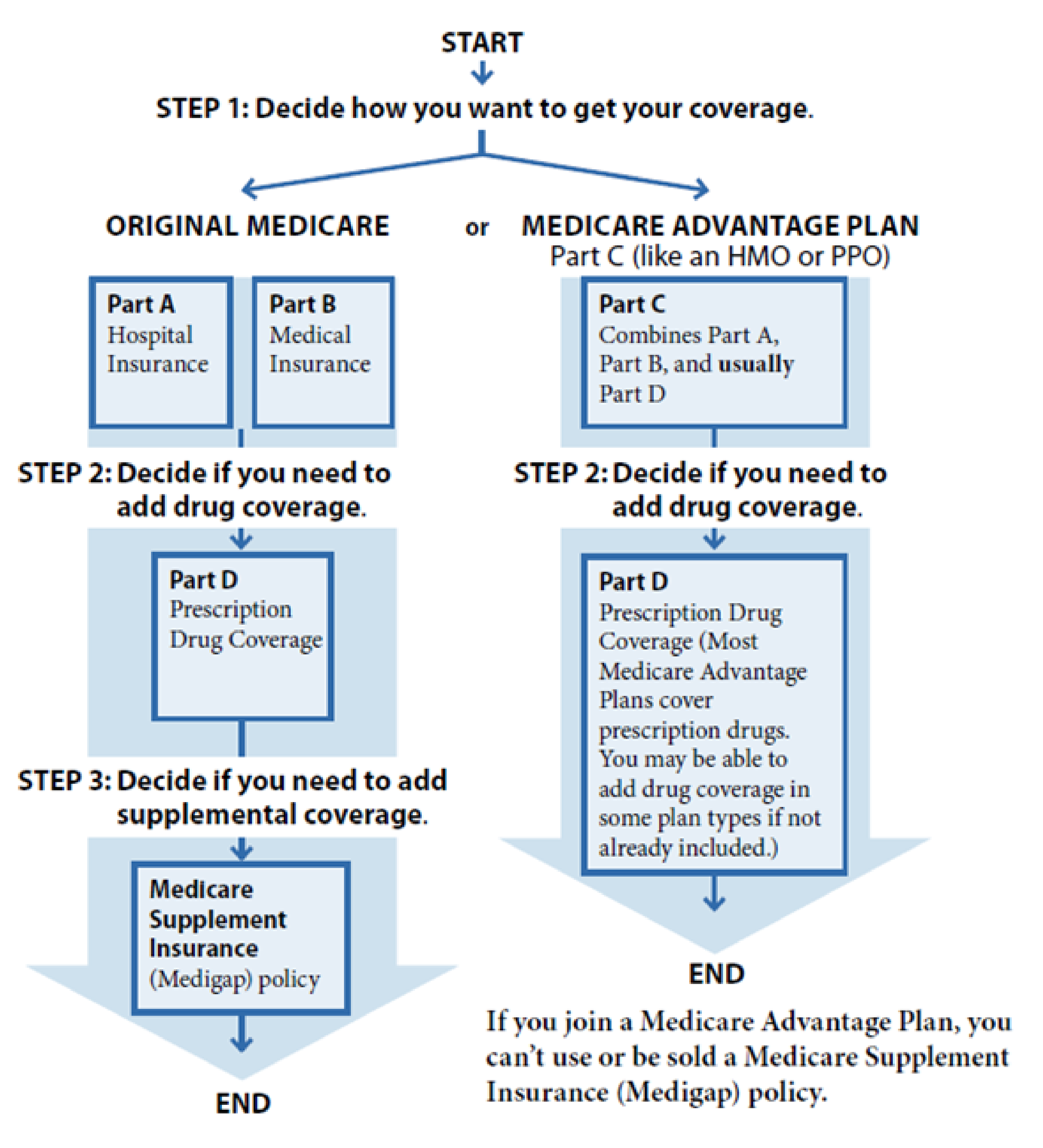
Your Medicare Coverage Choices



If you join a Medicare Advantage Plan, you can't use or be sold a Medicare Supplement Insurance (Medigap) policy.

You must have both Parts A & B in order to sign up for a Medicare Advantage plan (Part C)

If choosing an HMO or PPO, you must get your Part D prescription drugs from that plan (not stand alone Part D)

Medicare Eligibility

ELIGIBILITY

Generally, a person is eligible for Medicare if they:

- Are age 65 years or older; and
- Are a U.S. Citizen; or
- A lawfully admitted non-citizen with 5 years' continuous residence at time of filing.

Work History (under their own work history or their spouse's work history)

- Affects Medicare premiums, but not eligibility
- For monthly premium-free Part A, have 10 years (40 quarters/units) of Medicare-covered employment
- Otherwise, you will pay a monthly premium for Part A

Other people may qualify for Medicare if they are:

- Under age 65 and receiving disability benefits from SSA or Railroad Retirement System for 24 months; or
- A person of any age who has End-Stage Renal Disease (ESRD) (is receiving regular dialysis or has received a kidney transplant due to kidney failure);
- An individual of any age who has been diagnosed with Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease.

NOTE: A divorced spouse can apply for Medicare benefits on the work record of their former spouse provided they were married a minimum of 10 years.

ENROLLMENT

Automatic:

Many individuals will automatically be enrolled into Part A and/or Part B of Medicare.

- Individuals who are already receiving federal retirement benefits (SSA retirement check) will not have to file an application for Medicare with their Social Security office or Railroad Retirement Board (RRB). Their coverage will automatically begin the first day of their 65th birthday month.
- If the individual is under age 65 and disabled, Part A and/or Part B should automatically begin on the 25th month after they have been receiving disability benefits from SSA or RRB.
- A Medicare card will be mailed out as early as 3 months prior to their 65th birthday or 25th month of disability award.
- If a person does not want to be enrolled into Medicare Part B, they should follow the instructions that come with the card and send back the form to delay enrollment. Should they keep the card, Medicare Part B will begin on their eligibility month and premiums will be charged.
- If a person has ALS, they will automatically qualify for both Part A and Part B the month their disability benefits begin.

Not Automatic:

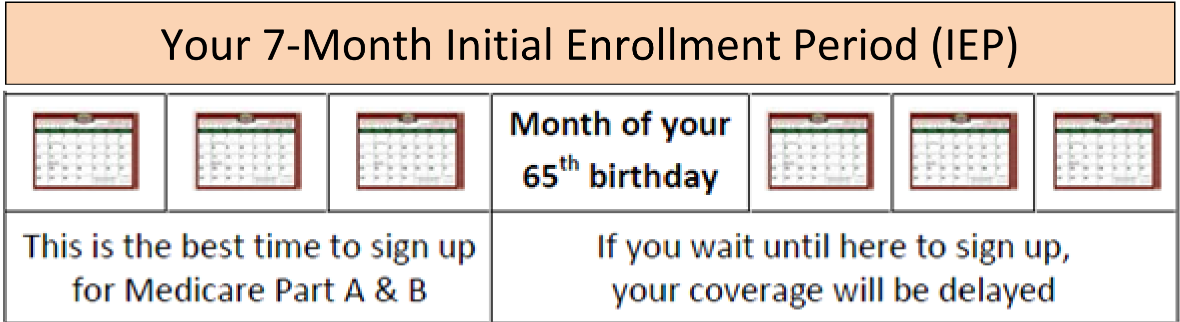
- There are many people who do not receive benefits from Social Security or RRB, such as people who have not reached their full SSA retirement age, are still working and have employer group health coverage or certain retired municipal employees.
- These individuals will need to contact SSA or RRB to sign up for Part A and/or Part B to enroll during one of the enrollment periods.
- When they sign up for Part A and/or Part B will depend on if they have other insurance coverage and what kind of coverage.
- Individuals with ESRD should visit their local SSA office or RRB to sign-up for Part A and Part B of Medicare or call SSA at 1-800-772-1213. TTY users should call 1-800-325-0778.

Who to Contact to Get your Medicare Questions Answered

<table>
<tr><th>If you . . .</th><th>Contact . . .</th></tr>
<tr><td>Want to:
Enroll in Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical insurance)
Check your Medicare eligibility or entitlement
Make changes to your personal information (such as your name or address)
Report a death
Replace your Medicare card
Ask about Medicare premiums
Apply for Extra Help with Medicare prescription drug costs</td><td>Social Security
1-800-772-1213
TTY:1-800-325-0778
socialsecurity.gov</td></tr>
<tr><td>Have a Medicare Prescription Drug Plan, a Medicare Advantage Plan (like an HMO or PPO), or a Medicare Supplement Insurance (Medigap) policy, and have questions about your plan or policy.</td><td>Your plan or policy
The phone number and website are on your membership card or in your plan materials.</td></tr>
<tr><td>Have railroad retirement benefits and want to:
Check Medicare eligibility
Enroll in Medicare
Replace your Medicare card
Change your name or address
Report a death</td><td>The Railroad Retirement Board
Your local office or 1-877-772-5772
TTY: (312) 751-4701
For questions about your Part B medical services and bills, call 1-800-833-4455.</td></tr>
<tr><td>Want to report changes to insurance that pays before Medicare:
Report that your other insurance is ending (for example, you stop working)
Report that you have new insurance (for example, you start working)</td><td>Benefits Coordination & Recovery Center (BCRC)
1-855-798-2627
TTY: 1-855-797-2627</td></tr>
<tr><td>Have Medicaid (Medical Assistance) and have questions.</td><td>Your State Medicaid office
http://www.dhs.state.il.us/page.aspx?item=29757
1-800-843-6154</td></tr>
</table>

Medicare Enrollment Periods - Quick Chart

Part A & B	Part D	Part C	Medigap
Medicare Initial Enrollment Period (IEP) 7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up for Medicare	**Medicare Initial Enrollment Period (IEP)** 7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up for Medicare	**Medicare Initial Enrollment Period (IEP)** 7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up for Medicare	**Medigap Open Enrollment Period (OEP) for guaranteed issue** One-time 6-month window after a person first enrolls in Part B
General Enrollment Period (GEP) (If missed IEP) Jan 1 – Mar 31 **Part D, if use GEP** April 1 – June 30 (eff July 1)		**General Enrollment Period** (If missed IEP) Jan 1 – Mar 31	
	Medicare Annual Open Enrollment Period (AOEP) for Parts C & D Oct 15 – Dec 7	**Medicare Annual Open Enrollment Period** (AOEP) for Parts C & D Oct 15 – Dec 7	
		Medicare Advantage (MA) Disenrollment Period (MADP) People in a Medicare Advantage (Part C) plan who wish to leave their plan to get Original Medicare (Parts A & B) January 1 – February 14	
Special Enrollment Period (SEP) Granted by Medicare in certain situations	**Special Enrollment Period (SEP)** Granted by Medicare in certain situations	**Special Enrollment Period (SEP)** Granted by Medicare in certain situations	**Note:** May have Special Rights and Guaranteed Issue Rules



Note: If you don't sign up during the IEP, coverage may be delayed and late penalties may apply

2018 Medicare Costs	Beneficiary Cost
PART A	
Benefit Period Deductible covering the first 60 days of Medicare-covered inpatient hospital care in a benefit period	$1,340
Daily coinsurance for the **61st through 90th** day of inpatient hospital care in a benefit period	$335
Daily coinsurance for the **91st through 150th** (lifetime reserve) days of inpatient hospital care in a benefit period	$670
Daily coinsurance for **beyond the150th** day of inpatient hospital care in a benefit period	All Costs
Skilled Nursing Facility (SNF) daily coinsurance for days **1 through 20** in a benefit period	$0.00
Skilled Nursing Facility (SNF) daily coinsurance for days **21 through 100** in a benefit period	$167.50
Part A Monthly Premium for beneficiaries with **40 quarters** of coverage	$0.00
Part A Monthly Premium for beneficiaries with **30-39 quarters** of coverage	$232.00
Part A Monthly Premium for beneficiaries with **less than 30 quarters** of coverage	$422.00
PART B	
Annual Deductible	$183.00 (Same as 2017)
Part B copays or coinsurance	Normally 20%
Part B Monthly Premium For beneficiaries not collecting Social Security (SS) benefits, those who will enroll in Part B for the first time in 2018, and those who have their Part B premiums paid by Medicaid	$134.00 (Same as 2017)
"Hold Harmless" provision - Part B Monthly Premium (See below)	Varies

- The **"hold harmless provision"** in the Social Security Act disallows an increase in the Medicare Part B premium for qualifying Social Security recipients if their COLA is not large enough to cover the increase in the Part B premium. **Part B enrollees who were held harmless in 2016 and 2017 will see an increase in the monthly Part B premium from the roughly $109, on average, they paid in 2017**.
- After several years of no or very small increases, Social Security benefits will increase by 2.0 percent in 2018 due to the Cost of Living adjustment. Therefore, some beneficiaries who were held harmless against Part B premiums increases in prior years will have a premium increase in 2018.
- The 30 percent of all Part B enrollees who are not subject to the "hold harmless" provision will pay the full premium of $134 per month in 2018.
- An estimated 42 percent of all Part B enrollees are subject to the hold harmless provision in 2018 but will pay the full monthly premium of $134, because the increase in their Social Security benefit will be greater than or equal to an increase in their Part B premiums up to the full 2018 amount.
- About 28 percent of all Part B enrollees are subject to the hold harmless provision in 2018 and will pay less than the full monthly premium of $134, because the increase in their Social Security benefit will not be large enough to cover the full Part B premium increase.
- Medicare Part B enrollees not subject to the "hold harmless" provision include beneficiaries who do not receive Social Security benefits, those who enroll in Part B for the first time in 2018, those who are directly billed for their Part B premium, those who are dually eligible for Medicaid and have their premium paid by state Medicaid agencies, and those who pay an income-related premium. These groups represent approximately 30 percent of total Part B beneficiaries.

Reference: CMS: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-17.html

2018 Original Medicare (Part A)
Inpatient Hospital Insurance
(Without Medigap or Secondary coverage)

Service	Benefit	Medicare Pays	Beneficiary Pays (Per benefit period)
Inpatient Hospitalization Semi–private room and board, general nursing, inpatient drugs and miscellaneous hospital services and supplies *(You begin a new Part A benefit period after you have been home for 60 consecutive days.)*	First 60 days	All but $1,340.00	$1,340.00
	61st to 90th day	All but $335.00 a day	$335.00 a day
	Lifetime Reserve Days		
	91st to 150th day (these 60 reserve days may be used only once in your lifetime)	All but $670.00 a day	$670.00 a day
	Beyond 150 days	Nothing	All Costs
Skilled Nursing Facility Care (SNF)* (Custodial care not covered)	First 20 days	Full cost of services	Nothing
	21st day through 100th day	All but $167.50 a day	$167.50 a day
	Beyond 100 days	Nothing	All costs
Home Health Care (After a prior inpatient hospital stay; up to 100 visits)	Visits limited to medically necessary part-time skilled care of a homebound individual	Full cost of services (See Durable Medical Equipment)	Nothing
Hospice Care Available to terminally ill	Unlimited renewable benefit period	All but limited costs for outpatient drugs and inpatient respite care	$5.00 for each outpatient prescription drug and 5% of Medicare-approved amount for respite care

*Beneficiary must be hospitalized under Part A inpatient hospital coverage for at least **three consecutive days** for the same illness prior to admission to the Medicare–approved SNF.

Reference: CMS**:** https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-17.html

1-800-252-8966

TTY #: 1-888-206-1327

2018 Original Medicare (Part B): Medical

(Without Medigap or Secondary coverage)

Service	Benefit	Medicare Pays	You Pay
Medical Expenses	Physician's services, some diagnostic tests, physical and speech therapy, ambulance, etc.	80% of approved amount (after $183.00 deductible) (Same as 2017)	$183.00 deductible* plus 20% of approved amount (plus any charge above approved amount)** (Same as 2017)
Home Health Care	Visits limited to medically necessary part–time skilled care of a homebound individual	Full cost of services (See Durable Medical Equipment)	Nothing
Outpatient Hospital Services	Medically necessary treatment such as outpatient surgery, diagnostic procedures, emergency room, etc.	A set amount for each specific procedure	Subject to deductible **plus copayment or coinsurance for each procedure**
Durable Medical Equipment (DME)	Medically necessary equipment and supplies such as walkers, wheel chairs, hospital beds, etc.	80% of approved amount (after $183.00 deductible) (Same as 2017)	20% of approved amount plus $183.00 deductible, plus charges above approved amount unless supplier accepts assignment (Same as 2017)

* Once you have had $183.00 of expenses for covered services, the Part B deductible is met for the rest of the calendar year.

** You pay for charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as payment in full (accepts assignment). Excess charges for physician services cannot exceed 15% of the Medicare-approved amount.

Medicare Part D pays for outpatient prescription drugs you can take on your own. However, Medicare Part A or B helps pay for certain oral anti–cancer drugs and immunosuppressive drugs taken after an organ transplant.

Note: The Part B monthly premium is $134.00 (varies for "held harmless" individuals) depending on beneficiary circumstances. Beneficiaries who have an income greater than $85,000 may experience monthly Part B premiums anywhere from $187.50 to $428.60.

1-800-252-8966

TTY #: 1-888-206-1327

2018 Part D

STANDARD COVERAGE and COST of DRUG BENEFIT

Benefit Stage	Coverage Range	Medicare / Plan Pays		Beneficiary Pays
Stage 1 **Annual Deductible** *Pre-Initial Coverage*	$0 - $405 If choosing a plan with a deductible, the beneficiary pays the first $405 in total drug costs, out of pocket, before the plan begins to pay its share.	0%	$0	100% up to $405*
Stage 2 **Initial Coverage** *Copay - Coinsurance*	$405 - $3,750 After the deductible is met (in total drug costs), the plan and the beneficiary begin paying their share of drug costs (75%/25%)	75% Average 75% of $3750 =$2813		25% Average 25% of $3750 = $937
Stage 3 **Coverage Gap (*Donut Hole*)**	$3,750- $5,000 Out of pocket threshold The coverage gap begins when total drug costs (the plan and beneficiary total cost, plus the deductible) reach $3,750, and lasts until the beneficiary has paid $5,000 out of pocket. The plan and beneficiary pay their percentage of cost. In the gap	65% - Brand Name 56% - Generic		35% Brand Name 44% Generic
Stage 4 ***Catastrophic Coverage***	$5,000 and Up When the beneficiary's total out-of-pocket cost reaches $5,000, catastrophic coverage begins and continues for the remainder of the calendar year.	95%	No Maximum	The higher of: $3.35 Generic $8.35 Brand or 5%

Extra Help Copays

Extra Help Full Benefit: (Full Dual Eligible Medicare Medicaid)	Copay $1.25 Generic $3.70 Brand
Extra Help Full Benefit (without Medicaid) Or Extra Help Partial benefit	Copay $3.35 Generic $8.35 Brand

* - In some plans, preferred generics are not subject to the deductible

Note: Out-of-pocket expenses are only the copayments, not including the premium.

2018 Part D National Base premium is $35.02

Reference: 2018 Final Call Letter, page 48: https://www.cms.gov/mwg-internal/de5fs23hu73ds/progress?id=jHy7C-tB9xfdtnZ5Kt2vYLXUwC8KDhyZ_HiCZ6aj0Nk

Reference: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2018.pdf

2017/2018 - Extra Help with Part D Drug Costs

Medicare beneficiaries can qualify for Extra Help (from Social Security) with their Medicare prescription drug plan costs. To qualify for the Extra Help, a person must be receiving Medicare, have limited resources and income, and reside in one of the 50 States or the District of Columbia. Apply at SSA.gov

2018 Income level not released yet

	Medicare & Medicaid **Full Benefit Dual** **Institutionalized** or receiving **Home & Community Based Services (HCBS)** ***Includes CCP services***	**Medicare & Medicaid** **Full Benefit Dual** 100% FPL $1,005 Individual $1,353 Couple (+ $25 income disregard)	**Medicare & MSP** **Medicare Savings Program (QMB, SLMB, QI)** **Up to 135% FPL** $1,356 Individual $1,826 Couple (+ $25 income disregard	**Medicare Only** 135% FPL $1356 Individual $1826 Couple	**Medicare Only** **150% FPL** *$1,508 Individual* *$2,030 Couple*
		Medicaid Resource Limit $2,000 Individual $3,000 Couple	**2018 Resources/Asset Limit** $7,560 (Individual) $11,340 (Couple) (Add $1,500 if claim burial allowance)	**2018 Resources/Asset Limit** $12,600 (Individual) $25,150 (Couple) (Add $1,500 if claim burial allowance)	**20018 Resources/Asset Limit** $12,600 (Individual) $25,150 (Couple) (Add $1,500 if claim burial allowance)
Monthly Part D Premium	**Full Premium Subsidy** **$0**	**Full Premium Subsidy** **$0**	**Full Premium Subsidy** **$0**	**Full Premium Subsidy** **$0**	***Partial Premium Subsidy*** **Sliding scale** 136-140% = 75% premium subsidy 141-145% = 50% premium subsidy 146-149% = 25% premium subsidy
Annual Deductible	**$0**	**$0**	**$0**	**$0**	**$82**
Copay Coinsurance	**$0**	**$1.25 / $3.70** Copay for 2018	**$3.35 / $8.35** Copay for 2018	**$3.35 / $8.35** Copay for 2018	15% Coinsurance Up to $4950 out-of-pocket
Catastrophic coverage	N/A	N/A	N/A	N/A	**$3.35 / $8.35** Copay After $4,950 out-of-pocket cost

Note: 2018 resource limits do not include $1,500 per person for burial expenses.

2017 FPL: 100% FPL = $12,060 for an individual annually & $16,240 for a couple annually

Reference: SSA POMS HI 03001.005 Medicare Part D Extra Help https://secure.ssa.gov/poms.nsf/lnx/0603001005

Reference: *HHS.gov Federal 2017 Poverty Level Guidelines* https://aspe.hhs.gov/poverty-guidelines

Reviewed by SSA Springfield (Sandy Leith email 01/31/17)

2017 Medicare Savings Programs (QMB, SLIB, QI-1)

The Medicare Savings Program (MSP) is a State Medicaid program that can help to pay Medicare premiums, and possibly deductibles, and coinsurance for Medicare beneficiaries (elderly or disabled) who qualify.

You can apply at: https://abe.illinois.gov/abe/access/ **2018 Income level not released yet**

Program Name	2017 Monthly Income Limits	Resource/Asset Limits	Program Pays	Effective Date
Qualified Medicare Beneficiary **(QMB)**	**100% FPL** $1,005 Individual (+ $25) $1,353 Couple (+ $25)	$7,280 Individual $10,930 Couple	Part A & B Premiums, deductibles, & coinsurance	Premiums are paid effective the month of QMB eligibility which is (the month after the month of the QMB eligibility determination.
Specified Low-Income Medicare Beneficiary **(SLIB/SLMB)**	**120%FPL** $1,205 Individual (+ $25) $1,623 Couple (+ $25)	$7,280 Individual $10,930 Couple	Medicare Part B premiums	Part B premium paid for application month & may be backdated an additional 3 months
Qualified Individual–1 **(QI-1)**	**135 % FPL** $1,356 Individual (+ $25) $1,826 Couple (+ $25)	$7,280 Individual $10,930 Couple	Medicare Part B premiums	Part B premium paid for application month & may be backdated an additional 3 months

(+ $25) *= Illinois Medicaid income disregard*

MSP Income limits are effective April 2017 *per Illinois Healthcare & Family Services (HFS): No change in resource limits.*

2017 FPL: 100% FPL = $12,060 for an individual annually & $16,240 for a couple annually

Estate recovery is eliminated for MSP per the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) http://www.dhs.state.il.us/page.aspx?item=60004

Reference: *SSA POMS HI 03001.005 Medicare Part D Extra Help* *https://secure.ssa.gov/poms.nsf/lnx/0603001005*

Reference: *HHS.gov Federal 2017 Poverty Level Guidelines* https://aspe.hhs.gov/poverty-guidelines

Reference: *SSA POMS HI 03030.025 Resource Limits for Subsidy Eligibility* *https://secure.ssa.gov/poms.nsf/lnx/0603030025*

Chart reviewed by Glenda Mason of HFS 02/06/17

For higher income individuals

2018 Income-Related Monthly Adjustment (IRMA) for Medicare Part D and Part B Monthly Premium

If your 2016 Annual Income is		In 2018 You Pay	
File Individual Tax Return	**File Joint Tax Return**	**Part D IRMA**	**Part B Monthly Premium** (Same as 2017)
$85,000 or less	$170,000 or less	$0.00	$134.00
$85,001 - $107,000	$170,001 - $214,000	$13.00	$187.50
$107,001 - $133,500	$214,001 - $267,000	$33.60	$267.90
$133,501 - $160,000	$267,001 - $320,000	$54.20	$348.30
Above $160,000	Above $320,000	$74.80	$428.60
You are married but filed separate tax return		**You Pay**	
$85,000 or less		$0.00	$134.00
Above $85,000		$74.80	$428.60

Part D Reference: https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html
Part B Reference: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-17.html

2018 Medicare Supplement Plans

Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A coinsurance and inpatient hospital costs (up to an additional 365 days after Medicare benefits are used)	√	√	√	√	√	√	√	√	√	√
Medicare Part B coinsurance or copayment	√	√	√	√	√	√	50%	75%	√	√***
Blood (first 3 pints; if charged)	√	√	√	√	√	√	50%	75%	√	√
Part A hospice care coinsurance or copayment	√	√	√	√	√	√	50%	75%	√	√
Skilled nursing facility care coinsurance			√	√	√	√	50%	75%	√	√
Part A deductible		√	√	√	√	√	50%	75%	50%	√
Part B deductible			√		√					
Part B excess charges					√	√				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-Pocket Limit in 2018**							**$5,240**	**$2,620**		

***Plan F is also offered as a high-deductible plan** by some insurance companies. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of **$2,240 in 2018** before your policy pays anything.

** **For Plans K and L**, after you meet your **out-of-pocket yearly limit** and your yearly Part B deductible **($183 in 2018)**, the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** **Plan N** pays 100% of the Part B coinsurance, except for a **copayment** of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

Reference for Plan F-HD: https://www.cms.gov/Medicare/Health-Plans/Medigap/FandJ.html
Reference for Plan K & L: https://www.cms.gov/Medicare/Health-Plans/Medigap/KandL.html

Medicare Supplement Insurance Fact Sheet

(MedSup/Medigap)

Medicare Supplement Insurance (Medigap/MedSup) policies, sold by private insurance companies, help pay some of the health care costs that Medicare doesn't cover.

1 – Medigap Open Enrollment:

Beneficiaries have a **6-month Medigap Open Enrollment Period** which starts the first month they're **65** and enrolled in Part B or **under 65 and qualify for Medicare due to disability** and enrolled in Part B.

- This period gives them a **guaranteed right** to buy any Medigap policy sold in their state regardless of their health status.
- The issuing company may impose a **pre-existing condition waiting period** (**6 months maximum)** due to medical underwriting, unless they have had "creditable" and "continuous" coverage (no break in coverage of more than 63 days).

2 – Purchasing a Medigap Policy *"after"* the Medigap Open Enrollment Period or without a Guaranteed Issue Right

- A person on **Medicare age 65 and above** can purchase or change Medigap policies at any time, but it is not guaranteed that the company will issue one.
  - Never cancel an existing Medigap before the replacement Medigap is in place.
- Medicare Beneficiaries **under age 65 and on Medicare due to disability** have a Medigap Special Enrollment Period (SEP)
  - In Illinois, an additional *Medigap guaranteed Special Enrollment* Period for people on Medicare with a disability under age 65 is available once each year. This protection exists for those individuals who did not purchase a Medigap during their initial Medigap Open Enrollment Period when they first went on Medicare Part B.
  - This guarantee gives the beneficiary the right to purchase a policy with a "guaranteed issue company" *only and only during specific times.* (see below)

Note: Illinois does not mandate guaranteed issue (GI) law. The companies choose to be a guaranteed issue company. As there is no law or rule about this in Illinois, the companies may choose to administer their GI policies as they wish.

The two Medicare Supplement "Guaranteed Issue Companies" in Illinois
BLUE CROSS/BLUE SHIELD OF ILLINOIS www.bcbsil.com 800/646-3000 BC/BS Medicare Supplement "guarantee issue" annual open enrollment for Medicare disabled individuals under 65 is October 15-December 7 of each year.
HEALTH ALLIANCE MEDICAL PLANS www.HealthAllianceMedicare.org 800/965-4022 Health Alliance Medicare Supplement "guarantee issue" annual open enrollment for Medicare disabled individuals under 65 is October 15-December 7 of each year. (This was approved by the Illinois DOI in 2010)

Important Notes:

- When a Medicare beneficiary who is on Medicare due to disability, turns age 65, they are eligible for a ***second Medigap open enrollment period*** to purchase any Medigap policy, guaranteed issue, at age 65 premium rates.
- There are also **a few very specific situations that may allow special rights and/or guaranteed issue**.

Full Benefit Dual Eligibility (FBDE) – Medicare and Medicaid Medical

These individuals have income of 100% FPL or less and resources that are within the Illinois Medicaid standards, and are eligible for full Medicaid benefits.

2018 Income level not released yet

Medicaid Monthly Income and Resource Standards (2017)			
Program	**Single Person**	**Couple**	**Resource/Asset Limit**
AABD **Aged, Blind or Disabled** **100% FPL**	$1,005 (+25)	$1,353 (+25)	$2,000 single $3,000 couple
ACA Adult (Age 19-64, not yet Medicare eligible) **138% FPL**	$1386 (+25)	1867 (+25)	No Resource Limit

(+25) = Illinois Medicaid Income Disregard

SHIP counselors may see beneficiaries who turn age 65, become Medicare eligible and transition from ACA Adult Medicaid to AABD.

- Many times, the beneficiary may become a Spenddown* case due to the lower income standard (100% FPL versus 138%) and the AABD resource limit.

Using Medicaid Spenddown to Get "Extra Help" with Part D

Beneficiaries only need to meet their Medicaid spend down one time during the year to be deemed a dual eligible by Medicaid and SSA.

They will then automatically receive Extra Help for the rest of the year. However, the month they meet their spend-down will determine if they receive Extra Help the following year as well.

- Beneficiaries who meet their spend-down at least once **before** July 1st of the year will automatically qualify for Extra Help for the remainder of the calendar year.
- Individuals who meet their spend-down at least one month **between July – December** will automatically receive Extra Help for the remainder of that year *and* the entire following calendar year.

Spenddown explained:

Spenddown is another way to qualify for Medicaid monthly even if a person's income or resources are **above** the state's eligibility limits. Spenddown works like an **insurance deductible.** That "deductible" is calculated by the **difference** between the Medicaid eligibility standards and one's income and resources.

That difference, or deductible, must be "spent down" **monthly** by the beneficiary to reach the eligibility standard. One **"meets"**, or receives credit for, that monthly spenddown amount through payments, medical receipts, and/or demonstrated liability for eligible medical bills. If a Medicare beneficiary meets a Medicaid Spenddown, on that met month they are considered **dual eligible** and may also qualify for Extra Help benefits.

Example:

Gross income	$1,200
Minus Medicaid Income Disregard	- $25
Countable income	$1,175
Minus Medicaid income limit for a single person (2017)	$1,005
Monthly Spenddown amount	**$170**
Note: Payments made by SSA Extra Help or Medicare Savings Program (MSP) are **not** counted toward the Spenddown limit.	

Example:

Assets Available	$6000
Resource Limit	**-** $2000
Resource Spenddown	**$4000**

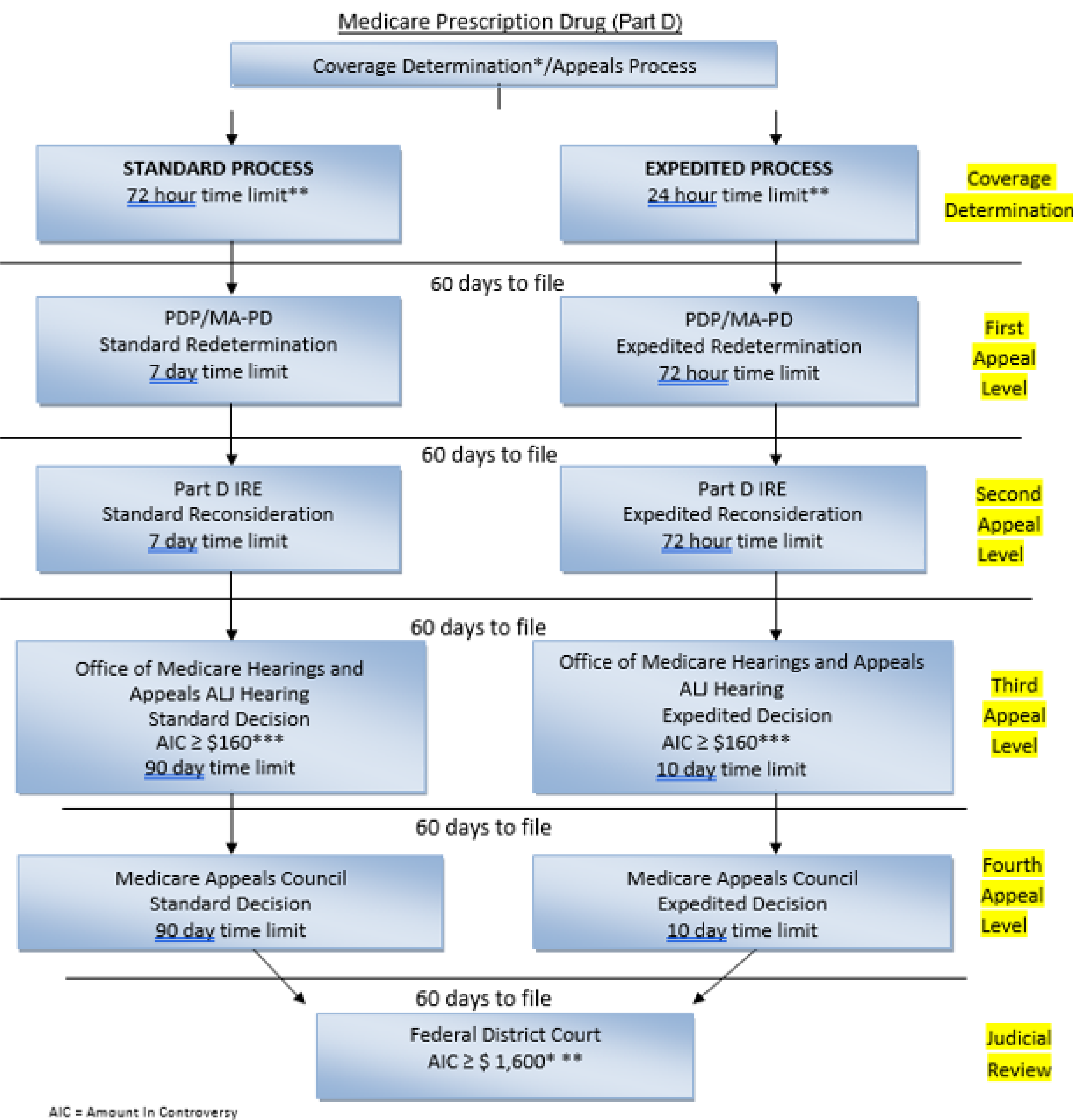
2018 Original Medicare (A & B) Appeals Process

After utilizing the denied claim appeal process on page 5 of the Medicare Summary Notice (MSN)

Level	Summary of Review process	Who Performs the Review	Deadline to Request an Appeal	When Beneficiary Should Get a Decision	Amount in Controversy (AIC)
1st Level – Redetermination	A document review of the initial claim determination	Medicare Administrative Contractor (MAC)	Up to **120 days** after receiving the initial determination on Medicare Summary Notice (MSN)	60 days	No
2nd Level – Reconsideration	A document review of the determination (present any evidence not previously submitted)	Qualified Independent Contractor (QIC)	Up to **180 days** after receiving Medicare Redetermination Notice (MRN)	60 days	No
3rd Level – Administrative Law Judge (ALJ) Hearing	May be an on-the- record review or an interactive hearing between parties	Administrative Law Judge (ALJ)	Up to **60 days** after receiving Qualified Independent Contractor (QIC) notice of decision or after expiration of the QIC reconsideration timeframe if no decision received	90 days, but may be delayed due to volume	**$160** (Same as 2017)
4th Level – Medicare Appeals Council Review	A document review of the ALJ's decision or dismissal (you may request oral arguments)	Medicare Appeals Council	Up to **60 days** after receiving ALJ notice of decision or after expiration of the ALJ hearing timeframe if no decision received	90 days if appealing an ALJ decision or 180 days if ALJ review time expired without a decision	No
5th Level – Judicial Review	Judicial review	U. S. District Court	Up to **60 days** after receiving notice of Medicare Appeals Council decision or after expiration of the Medicare Appeals Council hearing timeframe if no decision received	No statutory time limit	**$1600**

AIC = Amount in Controversy
2018 AIC for ALJ = $160.00
2018 AIC for ALJ Hearing = $1600
Reference: CMS.gov https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html
Reference: CMS.gov https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html

2018 Part D Appeals



AIC = Amount In Controversy
ALJ = Administrative Law Judge
IRE = Independent Review Entity
MA-PD = Medicare Advantage plan that offers Part D benefits
PDP = Prescription Drug Plan

*A request for a coverage determination includes a request for a Tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, by the enrollee's appointed representative or by the enrollee's physician or other prescriber.

**The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.

***The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2018.

Who Pays First?

If you…	*Condition*	*Pays First*	*Pays Second*
Are covered by Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid
Are 65 or older and covered by a group health plan because you or your spouse is still working	Entitled to Medicare The employer has 20 or more employees (See page 12 for informationabout multi-employer and multiple employer group health plans.)	Group health plan	Medicare
	The employer has less than 20 employees	Medicare	Group health plan
Have an employer group health plan through your former employer after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree coverage
Are disabled and covered by a large group health plan from your work, or from a family member (like spouse, domestic partner, son, daughter, or grandchild) who's working	Entitled to Medicare The employer has 100 or more employees	Large group health plan	Medicare
	The employer has less than 100 employees (See page 12 for informationabout multi-employer and multiple employer group health plans.)	Medicare	Group health plan
*Have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Have ESRD and COBRA coverage	First 30 months of eligibility or entitlement to Medicare based on having ESRD	COBRA	Medicare
	After 30 months	Medicare	COBRA

Who Pays First?

(Continued)

If you…	*Condition*	*Pays First*	*Pays Second*
Are 65 or over OR disabled (other than by ESRD) and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or liability insurance for services or items related to accident claim	Medicare
Are covered under workers' compensation because of a job-related illness or injury	Entitled to Medicare	Workers' compensation for services or items related to workers' compensation claim	Usually doesn't apply. However, Medicare may make a conditional payment(a payment that must be repaid to Medicare when a settlement, judgment, award, or other payment is made.)
Are a Veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services or items. Veterans' Affairs pays for VA-authorized services or items. **Note:** Generally, Medicare and VA can't pay for the same service or items.	Usually doesn't apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services or items. TRICARE pays for services or items from a military hospital or any other federal provider.	TRICARE may pay second.
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	The Federal Black Lung Benefits Program for services related to black lung.	Medicare