2023 Original Medicare

You pay for services as you get them. When you get a covered service, Medicare pays part of the cost and you pay your share.

You can see any doctor or hospital that takes Medicare, anywhere in the U.S.

Includes:

Part A Monthly (if 40 Qtrs.) $00.00

Part B Monthly premium $164.90

You can add:

Drug coverage (Part D) costs vary by plan & drugs taken:

Monthly premium _____

Monthly copays _____

You can also add:

Supplemental coverage (to help pay your share of costs): Medicare Supplement Insurance (Medigap) OR , coverage from a former employer or union, or Medicaid

Medigap Monthly Costs: _____

Medicare Advantage (Part C)

You join a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage.

In many cases, you'll need to use doctors who are in the plan's network

Includes: Under 1 Health Plan

Part A Monthly (if 40 Qtrs.) $00.00

Part B Monthly premium $164.90

Most plans include:

Drug coverage (Part D) costs vary by plan & drugs taken:

Monthly premium _____

Monthly copays _____

Can also include:

Can have some extra benefits (that Original Medicare doesn't cover – like vision, hearing, and dental services)

Note: You must have both Part A and Part B to join a Medicare Advantage Plan.

Part A (Hospital Insurance): Helps cover inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care.

Part B (Medical Insurance): Helps cover physician visits, outpatient care, home health care, durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment) and many preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits)

Part D (Drug coverage): Helps cover the cost of prescription drugs (including many recommended shots or vaccines). You join a Medicare drug plan in addition to Original Medicare

Medicare Supplemental Insurance (Medigap): Insurance you can buy from a private company that helps pay your specific shares of costs in Original Medicare. Policies are standardized, and in most states named by letters, like Plan G or Plan K. The benefits in each lettered plan are the same, no matter which insurance company sells it.
Note: Individuals may have other secondary insurance (retire plan, Medicaid, etc.) and therefore may not need a Medigap

Part C (Medicare Advantage Plan): Wraps your Part A & Part B together under one Medicare contracted health plan (HMO, PPO, etc.) that follows rules set by Medicare. Most plans include drug coverage and may provide extra benefits (vision, dental, hearing, etc.).

This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

Medicare Eligibility & Enrollment

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.

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 the type 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.

This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

Who to Contact to Get Your Medicare Questions Answered

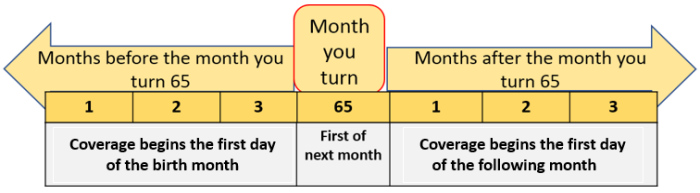
If you...	Contact…
Want to: • Enroll in Medicare Part A (Hospital Insurance) • and/or Medicare Part B (Medical • insurance) • Check your Medicare eligibility or entitlement • Make changes to your personal information (such as your name or • address) • Report a death • Replace your Medicare card • Ask about Medicare premiums • Apply for Extra Help with Medicare prescription • drug costs	**Social Security** 1-800-772-1213 TTY:1-800-325-0778 socialsecurity.gov
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.	**Your plan or policy** The phone number and website are on your membership card or in your plan materials.
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	**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.
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)	**Benefits Coordination & Recovery Center (BCRC)** 1-855-798-2627 TTY:1-855-797-2627
Have Medicaid (Medical Assistance) and have questions.	**Your State Medicaid office** http://www.dhs.state.il.us/page.aspx?item=29757 (800) 843-6154

SHIP
1-800-252-8966

This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

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	**If use GEP,** **Can sign up for Part D,** April 1 – June 30	**If use GEP,** **Can sign up for Part C,** April 1 – June 30	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. Beneficiaries **under 65 & on Medicare due to disability** do not have the same right as the Age 65 people above BUT have **a** Medigap Special Enrollment Period (SEP) **(Oct 15-Dec 7**) an Illinois guaranteed Issue Company. In Illinois, an additional Medigap guaranteed Special Enrollment Period, for people on Medicare due to disability, is available. 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.
	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 Open Enrollment Period (MA-OEP) One-time change between January 1- March 31. Must already be enrolled in a MA plan on Jan 1st. Can switch to a different MA Plan, with or without drug coverage. Can return to Original Medicare and enroll in Part D. Cannot switch from one PDP to another.	
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 do not sign up during the IEP, coverage may be delayed, and late penalties may apply

This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

2023 Basic Medicare Costs
(Without Medigap or Secondary Coverage)

Part A	Beneficiary Cost
Benefit Period Deductible covering the first 60 days of Medicare-covered inpatient hospital care in a benefit period	**$1,600.00**
Daily coinsurance for the **61st through 90th** day of inpatient hospital care in a benefit period	**$400.00** a day
Daily coinsurance for the **91st through 150th** (lifetime reserve) days of inpatient hospital care in a benefit period	**$800.00** a day
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	**Nothing**
Skilled Nursing Facility (SNF) daily coinsurance for days **21 through 100** in a benefit period	**$200.00** a day
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	**$278.00**
Part A Monthly Premium for beneficiaries with **less than 30 quarters** of coverage	**$506.00**

Part B	Beneficiary Cost
Part B Monthly Premium	**$164.90**
Annual Deductible	**$226.00**
Part B Copays or Coinsurance	**Normally 20%**
Part B Monthly Premium for 36-month post kidney transplant immunosuppressive drug eligibility	**$97.10**

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Reference: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts-b-premiums-and-deductibles-2023-medicare-part-d-income-related-monthly

This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

2023 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 $1,600.00	**$1,600.00**
	61st to 90th day	All but $400.00 a day	**$400.00** a day
	Lifetime Reserve Days		
	91st to 150th day (these 60 reserve days may be used only once in your lifetime)	All but $800.00 a day	**$800.00** 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 $200.00 a day	**$200.00** 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.			

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1-800-252-8966

Reference: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts-b-premiums-and-deductibles-2023- medicare-part-d-income-related-monthly

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2023 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 $226.00 deductible)	**$226.00** annual deductible* plus 20% of approved amount (plus any charge above approved amount)**
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, wheelchairs, hospital beds, etc.	80% of approved amount (after **$226.00** deductible)	20% of approved amount plus **$226.00** annual deductible, plus charges above approved amount unless supplier accepts assignment

*Once you have had $226.00 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 a Medicare covered organ transplant.

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Reference: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts-b-premiums-and-deductibles-2023- medicare-part-d-income-related-monthly

This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

For Higher Income Individuals: 2023 Part B IRMAA

(Income-Related Monthly Adjustment Amount)

If your 2021 annual income is…		In 2023 you pay…	
Beneficiaries who file individual tax returns with income:	**Beneficiaries who file joint tax returns with income:**	**Income-related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $97,000	Less than or equal to $194,000	$0.00	$164.90
Greater than $97,000 and less than or equal to $123,000	Greater than $194,000 and less than or equal to $246,000	$65.90	$230.80
Greater than $123,000 and less than or equal to $153,000	Greater than $246,000 and less than or equal to $306,000	$164.80	$329.70
Greater than $153,000 and less than or equal to $183,000	Greater than $306,000 and less than or equal to $366,000	$263.70	$428.60
Greater than $183,000 and less than $500,000	Greater than $366,000 and less than $750,000	$362.60	$527.50
Greater than or equal to $500,000	Greater than or equal to $750,000	$395.60	$560.50
Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses:		**Income-related monthly adjustment amount**	**Total monthly premium amount**
Less than or equal to $97,000		$0.00	$164.90
Greater than $97,000 and less than $403,000		$362.60	$527.50
Greater than or equal to $403,000		$395.60	$560.50

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Reference: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts-b-premiums-and-deductibles-2023- medicare-part-d-income-related-monthly

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For Higher Income Individuals: 2023 Part B IRMAA

(Income-Related Monthly Adjustment Amount)

Part B Immunosuppressive Drug Coverage Only

If your 2021 annual income is…		In 2023 you pay…	
Beneficiaries who file individual tax returns with income:	**Beneficiaries who file joint tax returns with income:**	**Income-related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $97,000	Less than or equal to $194,000	$0.00	$97.10
Greater than $97,000 and less than or equal to $123,000	Greater than $194,000 and less than or equal to $246,000	$64.70	$161.80
Greater than $123,000 and less than or equal to $153,000	Greater than $246,000 and less than or equal to $306,000	$161.80	$258.90
Greater than $153,000 and less than or equal to $183,000	Greater than $306,000 and less than or equal to $366,000	$258.90	$356.00
Greater than $183,000 and less than $500,000	Greater than $366,000 and less than $750,000	$356.00	$453.10
Greater than or equal to $500,000	Greater than or equal to $750,000	$388.40	$485.50
Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses:		**Income-related monthly adjustment amount**	**Total monthly premium amount**
Less than or equal to $97,000		$0.00	$97.10
Greater than $97,000 and less than $403,000		$356.00	$453.10
Greater than or equal to $403,000		$388.40	$485.50

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Reference: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts-b-premiums-and-deductibles-2023- medicare-part-d-income-related-monthly

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2023 Part D Standard Coverage and Cost of Drug Benefit

Benefit Stage	Coverage Range	Plan & Manufacturer Pay	Beneficiary Pays
Annual Deductible	**$0 - $505** If choosing a plan with a deductible, the beneficiary pays up to the first $505 in total drug costs, out of pocket, before the plan begins to pay its share.	0% $0	100% up to $505*
Initial Coverage	**$505 - $4,660** After the deductible is met, the plan and the beneficiary begin paying their share of drug costs (75%/25%)	**75%** Average 75% of $4,660= $3,495	**Up to 25%** Average 25% of $4660 = $1,165
Coverage Gap	**Note: The Coverage Gap (Donut Hole) closed in 2020**, but if a plan is non-standardized and charges less than 25% in the annual deductible and initial coverage phases, the insured may see a price increase to 25% during the coverage gap. Beneficiaries may pay 25% of the drug's cost (at $4,660) until they get to catastrophic ($7,400) coverage.	Name brand Rx = 75% Generic Rx = 75%	Name brand Rx = 25% Generic Rx = 25%
Catastrophic Coverage	Above **$7,400** in out-of-pocket costs When the beneficiary's total out-of-pocket cost, not including the monthly premiums, reaches $7,400 catastrophic coverage begins and continues for the remainder of the calendar year.	95% No Maximum	The higher of: $4.15 Generic $10.35 Brand or 5%

Extra Help Copays	
Extra Help Full Benefit: (Full Dual Eligible Medicare Medicaid)	Copay **$1.45** Generic **$4.30** Brand
Extra Help Full Benefit (without Medicaid) Or Extra Help Partial benefit	Copay **$4.15** Generic **$10.35** Brand

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

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

2023 Part D National Base premium is **$32.74**

Reference: 2023 Announcement: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts- b-premiums-and-deductibles-2023-medicare-part-d-income-related-monthly

Reference 2023 National Base Premium: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts- b-premiums-and-deductibles-2023-medicare-part-d-income-related-monthly

Note about True Out-of-Pocket (TrOOP) costs:

The total amount spent in this period (up to **$5,856.25**) includes:

- The drug costs paid by the beneficiary, **and**
- The 70% discount on **brand-name** drugs provided by the drug manufacturer.

Payments made by the plan during this period (75% on **generics,** 5% on **brand-name** drugs) do not count toward TrOOP.

Reference: 2023 Announcement: https://www.cms.gov/files/document/2023-announcement.pdf

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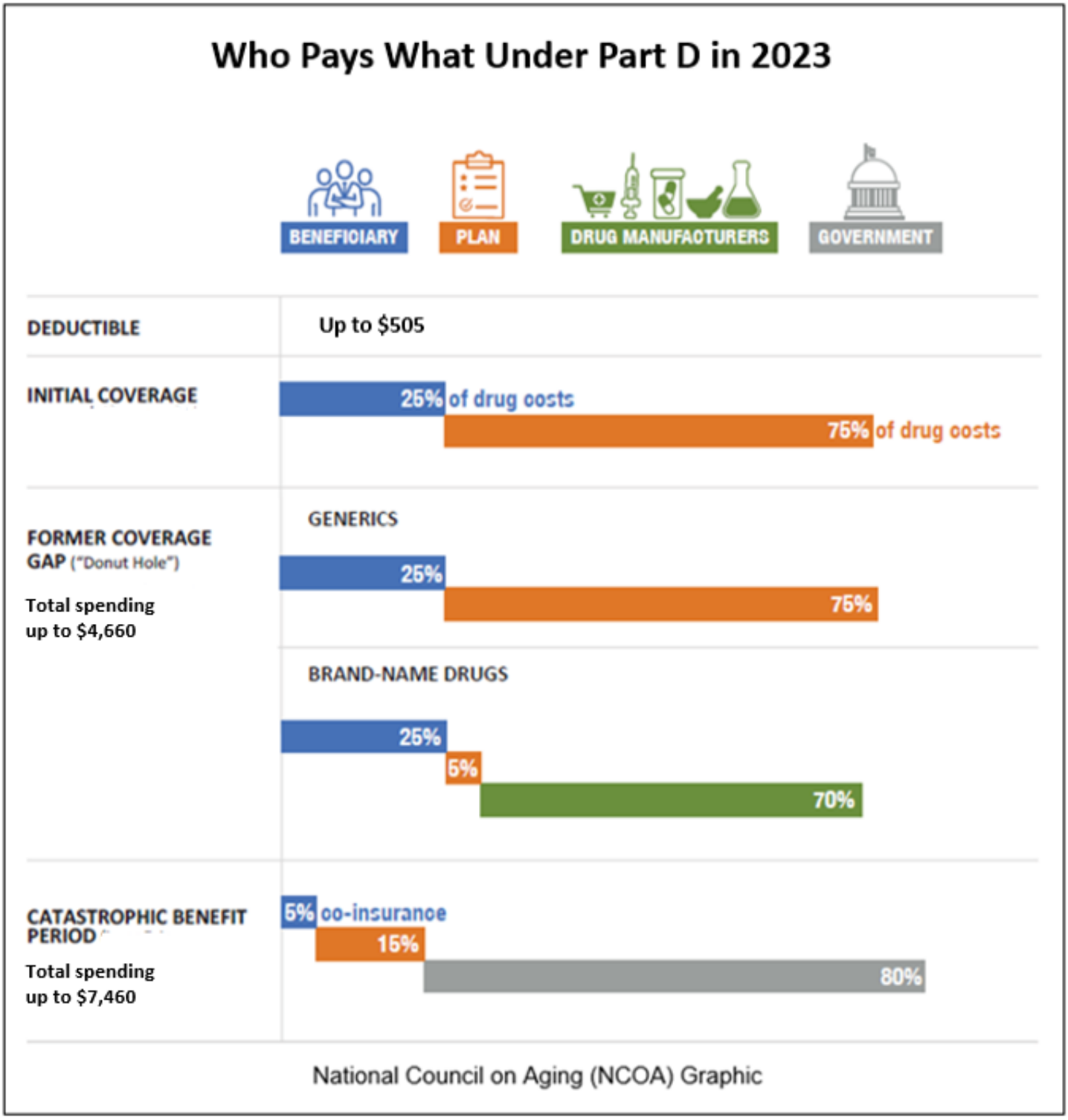
This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.



This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

For Higher Income Individuals: 2023 Part D IRMAA

(Income Related Monthly Adjustment Amount)

Based on 2021 Income for 2023

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Part D Income- Related Monthly Adjustment Amount
Less than or equal to $97,000.	Less than or equal to $194,000.	$0.00
Greater than $97,000 and less than or equal to $123,000.	Greater than $194,000 and less than or equal to $246,000.	12.20
Greater than $123,000 and less than or equal to $153,000.	Greater than $246,000 and less than or equal to $306,000.	31.50
Greater than $153,000 and less than or equal to $183,000.	Greater than $306,000 and less than or equal to $366,000.	50.70
Greater than $183,000 and less than $500,000.	Greater than $366,000 and less than $750,000.	70.00
Greater than or equal to $500,000.	Greater than or equal to $750,000.	76.40

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Reference: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts-b-premiums-and-deductibles-2023- medicare-part-d-income-related-monthly

This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

2022 - 2023 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.
NOTE: 2023 Extra Help income and asset limits have not been released

	Medicare & Medicaid Full Benefit Dual Institutionalized or receiving Home & Community Based Services (HCBS) Includes CCP Services	**Medicare & Medicaid** Full Benefit Dual 100% FPL **$1,133** Individual **$1,526** Couple	**Medicare & MSP** Medicare Savings Program (QMB, SLMB, QI) Up to 135% FPL **$1,528** Individual **$2,059** Couple	**Medicare Only** 150% FPL **$1,699** Individual **$2,289** Couple
Resource Limit	Medicaid or HCBS	**Medicaid Resource Limit** **$2,000** Individual **$3,000** Couple	**2022 Resources/Asset Limit** **$8,400** (Individual) **$12,600** (Couple) (Does not include $1,500 burial allowance) *	**2022 Resources/Asset Limit** **$14,010** (Individual) **$27,950** (Couple) (Does not include $1,500 burial allowance) *
Monthly Part D Premium	**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**	**$104**
Copay Coinsurance	**$0**	**$1.45 / $4.30** Copay for 2023	**$4.15 / $10.35** Copay for 2023	15% Coinsurance Up to ~~$5,100~~ out-of-pocket
Catastrophic Coverage	N/A	N/A	N/A	**$4.15 / $10.35** After $7,400 out-of-pocket cost

2022 FPL: 100% FPL = $13,590 for an individual annually & $18,310 for a couple annually
Reference: HHS.gov Federal 2022 Poverty Level Guidelines https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
Reference: 2023 Final Call Letter, page 65: https://www.cms.gov/files/document/2023-announcement.pdf
Reference: 2022 Asset/Resource Levels: SSA POMs https://secure.ssa.gov/apps10/poms.nsf/lnx/0603001005
Illinois Medicaid Reference: DHS WAG 25-03-02 https://www.dhs.state.il.us/page.aspx?item=21741
NOTE: Illinois Medicaid limits may differ from national limits.

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This project was supported in part by grant #90SAPG0101-02-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

2022 Illinois 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/

NOTE: 2023 MSP income and asset limits have not been released

Program Name	2022 Monthly Income Limits	Resource/ Asset Limits	Program Pays	Effective Date
Qualified Medicare Beneficiary (QMB)	**100% FPL** $1,133Individual $1,526 Couple	$8,400 Individual $12,600 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** $1,358 Individual $1,830 Couple	$8,400 Individual $12,600 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** $1,528 Individual $2,059 Couple	$8,400 Individual $12,600 Couple	Medicare Part B Premiums	Part B premium paid for application month & may be backdated an additional 3 months.

SENIOR HEALTH INSURANCE PROGRAM

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1-800-252-8966

NOTE: *Illinois Medicaid income standards differ from the national amounts*

Main Reference: DHS WAG 25-03-02 https://www.dhs.state.il.us/page.aspx?item=21741

Reference: **2022 FPL**: 100% FPL = $13,590 for an individual annually & $18,310 for a couple annually: https://aspe.hhs.gov/poverty-guidelines

Estate recovery is eliminated for MSP per MIPPA: http://www.dhs.state.il.us/page.aspx?item=60004

Note: *Illinois Medicaid limits may differ from national limits*

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2023 Medicare Supplement Plans

Benefits	A	B	C	D	F	FHD	G	GHD	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%			80%	80%

Plans C and F are only available to those eligible for Medicare prior to 01/01/20.

2023 Out-of-Pocket Limit **$6,940** **$3,470**

√ = 100%

Plans F & G are 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 **$2,700 in 2023** 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; 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 and G-HD: https://www.cms.gov/medicare/health-plans/medigap/fandj
Reference for Plan K & L: https://www.cms.gov/medicare/health-plans/medigap/kandl

NOTE: Your monthly premium will depend on plan selected, company purchased & benefit chosen

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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. Plans have a monthly premium.

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.
- Beneficiaries under 65 & on Medicare due to disability do not have the same right as the Age 65 people above
- BUT have a Medigap Special Enrollment Period (SEP) an Illinois guaranteed Issue Company.
    - In Illinois, an additional Medigap guaranteed Special Enrollment Period, for people on Medicare due to disability, is available. 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". (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.

Medicare Supplement "Guaranteed Issue Company" 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.

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.
- Medigap Open Enrollment cannot be repeated or changed (except as noted in first dot point above)

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2022 Illinois Medicaid Monthly Income and Resource Standards

NOTE: 2023 Medicaid income and asset limits have not been released

2022 Medicaid Program Standards and Allowances

Reference: WAG 25-03-02: (2) Medical http://intranet.dhs.illinois.gov/onenet/page.aspx-?item=21741#a_toc5

# in Household	ACA Adult		AABD		MSP			
	less than or = 138% FPL	2022 Asset Limit	100% FPL	Asset Limit	QMB 100% FPL	SLIB less than or = 120% FPL	QI-1 less than or = 135% FPL	2022 MSP AssetLimit
1	1563	No Limit	1133	$2,000	1133	1134-1358	1359-1528	$8,400
2	2106	No Limit	1526	3,000	1526	1527-1830	1831-2059	12,600 2 or more people
3			1919	3050				
4			2313	3100				
5			2706	3150				
6			3099	3200				
7			3493	3250				
8			3886	3300				
9			4279	3350				
10			4672	3400				
Each Additional			+393	+ 50				

Asset Limit Reference: PM 07-02-01 http://intranet.dhs.illinois.gov/onenet/page.aspx?item=14876

Full Benefit Dual Eligibility (FBDE) – Medicare and full 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.

Dual Eligibility – Medicare and any form of Medicaid coverage (i.e., Medicare Savings Programs (MSP) benefit)

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

Beneficiaries only need to meet their Medicaid spend down <u>one time</u> 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 calendaryear.

Individuals who meet their spend-down at least one month **between July - December** will automatically receive Extra Help for the remainder of that year ***<u>and</u>*** the entire following calendar year.

Spenddown explained:

"<u>Income Spenddown</u>" is another way to qualify for Medicaid, on a month-to-month basis, even if a person's income is 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: NOTE: 2023 Medicaid income and asset limits have not been released

Gross Income	$1,300
Minus Medicaid Income Disregard	- $25
Equals Countable Income	$1,275
Minus Medicaid Income Limit for a single person (2022)	$1,133 (2022 limit)
Monthly Spenddown Amount	**$142**
Note: Payments made by SSA Extra Help or Medicare Savings Program (MSP) are **not** counted toward the Spenddown limit	

"<u>Asset Spenddown</u>" is when assets/resources are above the state's asset eligibility limit. To be eligible, a person must "spend" assets on medical costs until resources are at or below the asset eligibility limit. They then become eligible for the year and asset eligibility is redetermined annually.

Example

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

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Who Pays First

If you…	*Condition*	*Pay 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 information about 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 information about 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

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Who Pays First

If you…	*Condition*	*Medicare*	*COBRA*
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

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2023 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	$180
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	$1850

AIC = Amount in Controversy

2023 AIC for ALJ = 180.00
2023 AIC for ALJ Hearing = $1850
Reference, Federal register: https://www.federalregister.gov/documents/2022/09/30/2022-21284/medicare-program-medicare-appeals-adjustment-to-the-amount-in-controversy-threshold-amounts-for

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