Medicare

Overview

Medicare is a federal health insurance program for individuals age 65 and older, individuals under age 65 with certain disabilities and individuals of any age with End-Stage Renal Disease (ESRD).

The Social Security Administration (SSA) or the Railroad Retirement Board (RRB)** determines Medicare eligibility upon application and enrolls eligible plan participants into the Medicare Program. The Medicare Program is administered by the Centers for Medicare and Medicaid Services (also known as the federal CMS).

Medicare has the following parts:

- **Part A** is insurance that helps pay for inpatient hospital facility charges, skilled nursing facility charges, hospice care and some home healthcare services. Medicare Part A does not require a monthly premium contribution from plan participants with enough earned work credits. Plan participants without enough earned work credits have the option to enroll in Medicare Part A and pay a monthly premium contribution.
- **Part B** is insurance that helps pay for outpatient services including physician office visits, labs, x-rays and some medical supplies. Medicare Part B requires a monthly premium contribution.
- **Part C** (also known as Medicare Advantage) is insurance that helps pay for a combination of the coverage provided in Medicare Parts A, B and sometimes D. An individual must already be enrolled in Medicare Parts A and B in order to enroll in a Medicare Part C plan. Medicare Part C requires a monthly premium contribution.
- **Part D** is insurance that helps pay for prescription drugs. Generally, Medicare Part D requires a monthly premium contribution.

Medicare Due to Age

Plan Participants Age 65 and older

The State Employees Group Insurance Program requires all plan participants to contact the SSA and apply for Medicare benefits three months prior to turning age 65.

Medicare Part A

Eligibility for premium-free Medicare Part A occurs when an individual is age 65 or older and has earned at least 40 work credits from paying into Medicare through Social Security. An individual who is not eligible for premium-free Medicare Part A benefits based on his/her own work credits may qualify for premium-free Medicare Part A benefits based on the work history of a current, former or deceased spouse. All plan participants that are determined to be ineligible for Medicare Part A based on their own work history are required to apply for premium-free Medicare Part A on the basis of a spouse (when applicable).

If the SSA determines that a plan participant is eligible for premium-free Medicare Part A and you are a retiree, or not actively working due to disability, **the State Employees Group Insurance Program requires that the plan participant accept the Medicare Part A coverage** and submit a copy of the Medicare identification card to the Department's Medicare COB Unit upon receipt.

If the SSA determines that a plan participant is **not eligible** for Medicare Part A benefits at a premium-free rate, the State Employees Group Insurance Program does not require the plan participant to purchase Medicare Part A coverage; however, the State does require the plan participant to provide a written statement from the SSA advising of his/her Medicare Part A ineligibility. The plan participant is required to submit a copy of the SSA statement to the Department's Medicare COB Unit.

Medicare Part B

Most plan participants are eligible for Medicare Part B upon turning the age of 65.

In order to apply for Medicare benefits, plan participants should contact the local Social Security Administration (SSA) office or call the SSA at 800-772-1213. Plan participants may enroll in Medicare on the SSA website at **ssa.gov/Medicare**.

**Railroad Retirement Board (RRB) participants should contact their local RRB office or call the RRB at 877-772-5772 to apply for Medicare.

Medicare (cont.)

The State Employees Group Insurance Program requires plan participants to enroll in Medicare Part B if they are eligible for Medicare Part A benefits at a contribution-free rate. Refer to the 'Failure to Enroll in Medicare' section for more information.

Total Retiree Advantage Illinois (TRAIL)

Medicare Advantage Prescription Drug Program

The State of Illinois offers retirees, annuitants, survivors and their covered dependents comprehensive medical and prescription drug coverage through a State-sponsored Medicare Advantage Prescription Drug Plan. In order to be eligible for the TRAIL MAPD Program, plan participants must be covered under a retiree plan, enrolled in Medicare Parts A and B due to age or disability, and be a resident of the United States (or a US territory). The Department of Central Management Services (CMS) will notify all eligible plan participants by mail 3 months prior to their 65th birthday of the requirement to enroll in Medicare. The participant will receive additional notification 60 days prior to their Medicare eligibility date to enroll in the TRAIL MAPD plan. Annual notices will be sent to participants prior to the TRAIL Open enrollment in the fall notifying them of their eligibility to make changes. The TRAIL Open Enrollment Period runs from the middle of October through the middle of November each year. All elections made during the TRAIL Open Enrollment Period will be effective January 1st. **All newly eligible plan participants must enroll** into the State-sponsored TRAIL plan, or optout of State insurance coverage during their initial enrollment period. All initial enrollment elections will be effective the first of the month in which the participant turns 65 or the first of the month following the election, whichever is later. **State retirees, annuitants, and survivors** waiving coverage will terminate the medical, prescription drug and vision coverage for you and all covered dependents, if applicable. Your current dental coverage (if enrolled) and life insurance coverage will remain in effect. Waiving TRAIL MAPD coverage does not allow you or your covered dependents to stay in your current State health plan. **Dependents** waiving coverage will only terminate your medical, prescription drug, vision and dental coverage. Waiving TRAIL MAPD coverage does not allow you to stay in your current State health plan. Plan participants already enrolled in the TRAIL Medicare Advantage Prescription Drug Plan are not required to make changes. Retirees, annuitants, and survivors may add, cancel, or waive the dental coverage for them and their covered dependents during their TRAIL MAPD Initial Enrollment and Annual Open Enrollment periods. Note: Dependents must mirror the same dental coverage as the retiree, annuitant, or survivor.

Medicare Split Family

Retired members and dependents who are eligible to enroll in Medicare Parts A and B are also required to enroll in a TRAIL Medicare Advantage Prescription Drug (MAPD) Program. Effective July 1, 2025, you or your dependent will be required to enroll in the TRAIL MAPD plan when you are first eligible for Medicare, either by age or disability.

If you currently cover 2 or more dependents, you nor your Medicare-eligible dependent(s) will be required to enroll in the TRAIL MAPD plan until there is only one covered dependent remaining or all covered dependents are Medicare eligible.

For more information regarding the Medicare Advantage Prescription Drug 'TRAIL' Program, go to MyBenefits.illinois.gov, or contact:

MyBenefits Service Center (toll-free) at 1-844-251-1777 or 844-251-1778 TDD/TTY

State of Illinois Medicare COB Unit
PO Box 19208
Springfield, Illinois 62794-9208
CMS.Ben.MedicareCOB@illinois.gov
Fax: 217-557-3973
Phone: 217-782-7007

Medicare Due to Disability

Plan Participants Age 64 and Under

Plan participants are automatically eligible for Medicare Parts A and B after receiving Social Security disability payments for a period of 24 months.

Medicare Part A

Plan participants who become eligible for Medicare disability benefits are **required** to accept the Medicare Part A coverage and submit a copy of the Medicare identification card to the Department's Medicare COB Unit upon receipt.

Medicare Part B

Plan participants who become eligible for Medicare disability benefits are **required** to accept the Medicare Part B coverage.

Medicare (cont.)

Refer to the 'Failure to Enroll in Medicare' section for more information.

Medicare Due to End-Stage Renal Disease (ESRD)

All State Employees Group Insurance Program plan participants who are receiving regular dialysis treatments or who have had a kidney transplant on the basis of ESRD are required to apply for Medicare benefits.

Plan participants must contact the Department's Medicare Coordination of Benefits (COB) Unit at 800-442-1300. The Department's Medicare COB Unit calculates the 30-month coordination period in order for plan participants to sign up for Medicare benefits on time to avoid additional out-of-pocket expenditures.

Medicare Part A

Plan participants who become eligible for Medicare benefits on the basis of ESRD are **required** to accept the Medicare Part A coverage and submit a copy of the Medicare identification card to the Department's Medicare COB Unit upon receipt.

Medicare Part B

The State Employees Group Insurance Program requires plan participants to enroll in Medicare Part B if they are eligible for Medicare Part A benefits at a contribution-free rate. Plan participants who become eligible for Medicare on the basis of ESRD are required to accept the Medicare Part B coverage when Medicare is determined to be the primary payer. Refer to the 'Failure to Enroll in Medicare' section for more information.

Medicare Coordination with the Quality Care Health Plan (QCHP)

When Medicare is the primary payer, QCHP will coordinate benefits with Medicare as follows:

Medicare Part A - Hospital Insurance

In-Network Provider: After Medicare Part A pays, QCHP pays 85% of the Medicare Part A deductible after the QCHP annual plan deductible has been met.

Out-of-Network Provider: After Medicare Part A pays, QCHP pays 60% of the Medicare Part A deductible after the QCHP annual plan deductible has been met.

Medicare Part B - Medical Insurance

In-Network Provider: After Medicare Part B pays, QCHP pays 85% of the balance after the QCHP annual plan deductible has been met.

Out-of-Network Provider: After Medicare Part B pays, QCHP pays 60% of the balance after the QCHP annual plan deductible has been met.

Failure to Enroll in Medicare

Medicare Parts A and B Reduction: Plan participants who do not enroll in Medicare Parts A and B are responsible for the portion of their healthcare costs that Medicare would have covered. Failure to enroll or remain enrolled in Medicare when Medicare is determined to be the primary payer will result in a reduction of eligible benefit payments.

Loss of Health Insurance Coverage Eligibility: Plan participants who do not enroll in Medicare Parts A and B when required according to the State Employees Group Insurance Program's requirements, could lose eligibility for continued health insurance coverage until enrollment in Medicare Parts A and B are completed.

Medicare COB Unit Contact Information

Department of Central Management Services
Medicare Coordination of Benefits Unit
801 S. 7th Street, P.O. Box 19208
Springfield, Illinois 62794-9208

Phone: 800-442-1300 or 217-782-7007
Fax: 217-557-3973

Services and Supplies Not Covered by Medicare

Services and supplies that are not covered by Medicare will be paid in the same manner (i.e., same benefit levels and deductibles) as if the plan participant did not have Medicare (provided the services and supplies meet medical necessity and benefit criteria and would normally be eligible for coverage).

Medicare Crossover QCHP Members

Medicare Crossover is an electronic transmittal of claim data from Medicare (after Medicare has processed their portion of the claim) to the QCHP plan administrator for secondary benefit determination.

In order to set up Medicare Crossover, plan participants must contact the QCHP plan administrator and provide the Medicare Health Insurance Claim Number (HICN) located on the front side of the Medicare identification card.

Private Contracts with Providers who Opt-Out of Medicare

Some healthcare providers choose to opt-out of the Medicare program. When a plan participant has medical services rendered by a provider who has opted-out of the Medicare program, a private contract is usually signed explaining that the plan participant is responsible for the cost of the medical services rendered. Neither providers nor plan participants are allowed to bill Medicare. Therefore, Medicare will not pay for the service (even if it would normally qualify as being Medicare eligible) or provide a Medicare Summary Notice to the plan participant. If the service(s) would have normally been covered by Medicare, the plan administrator will estimate the portion of the claim that Medicare would have paid. The plan administrator will then subtract that amount from the total charge and adjudicate the claim for any eligible secondary reimbursement. The difference between the total charge and the eligible reimbursement amount is the plan participant's responsibility.