2025 Wisconsin SHIP Counselor Toolkit

This packet is designed as a quick-reference tool for State Health Insurance Assistance Program (SHIP) counselors. It is not a comprehensive guide to eligibility and costs.

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Medicare Coverage Choices

Step 1:

Enroll in Medicare through Social Security.

The default coverage is Original Medicare Parts A and/or B.

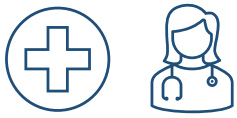
People already receiving Social Security benefits are automatically enrolled in Parts A and B.

Elderly, blind, and disabled Medicaid members with Medicaid managed care plans may be default enrolled in (start off with) a Dual Eligible Special Needs Plan, unless they opt out.

Step 2:

Choose how you want to get your coverage.

Without coverage you could incur penalties.



Original Medicare

Part A
Hospital insurance

and/or

Part B
Medical insurance

OR

Medicare Advantage (a.k.a. Part C)

Advantage plans bundle hospital and medical insurance.

You must have Medicare Parts A *and* B to be eligible.

Check if the plan covers prescription drugs.

Most do. You may be able to add drug coverage in some types of plans if it's not included.

Step 3:

Add drug coverage.

Without coverage you could incur penalties.

Part D

Prescription drug coverage

Step 4:

Decide if you want supplemental coverage.

Medicare Supplement (a.k.a. Medigap)

You must have Parts A *and* B to be eligible.

You can't have and don't need a Medigap.

Financial assistance programs

Medicaid, the Medicare Savings Program, Extra Help, and pharmaceutical assistance programs (like SeniorCare) work with both Original Medicare and Medicare Advantage.

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Who to Contact to Get Your Medicare Questions Answered	
If you…	**Contact…**
Want to: • Enroll in Medicare Part A and/or Part B • Check your Medicare eligibility or entitlement • Change your personal information (like 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 www.ssa.gov See also: "Who do I contact – Medicare or Social Security?" (SSA No. 05-10500)
Have questions about your current Part D plan, Medicare Advantage Plan (like an HMO or PPO), or Medicare Supplement Insurance (Medigap) policy	**Your plan or policy** See your membership card and the 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 questions about or want to apply for Medicaid (Medical Assistance)	**Your State Medicaid office** dhs.wisconsin.gov/medicaid 1-800-362-3002
Have questions about Medicare in Wisconsin	**Medigap Helpline:** 800-242-1060 **Part D Helpline:** 855-677-2783 **Office for the Deaf and Hard of Hearing:** 262-347-3045 videophone **Judicare Legal Aid:** 800-472-1638
Have questions about SeniorCare, the Wisconsin state prescription assistance program	**SeniorCare Hotline:** 1-800-657-2038 www.dhs.wisconsin.gov/seniorcare

Medicare Eligibility and Enrollment

Eligibility

- U.S. citizen **or** a lawfully admitted non-citizen with 5 years' continuous residence at time of filing, **and**
- 65 years or older, **or**
- **Under age 65 and receiving disability** benefits from Social Security or Railroad Retirement Board 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) starting the month of their kidney transplant or up to the fourth month after dialysis begins, **or**
- **A person of any age who has been diagnosed with Amyotrophic Lateral Sclerosis (ALS),** also known as Lou Gehrig's disease

Enrollment

Automatic

Certain individuals will automatically be enrolled in Part A and/or Part B of Medicare:

- **Retirement benefits:** Individuals who are already receiving federal retirement benefits (SSA retirement check) will be automatically enrolled into Parts A and B; coverage will begin the first day of their 65th birthday month.
- **Disability benefits:** 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 Railroad Retirement Board (RRB).
- Disabled individuals with Medicaid managed care (HMO or MCO) may be "default enrolled" in a Dual Eligible Special Needs Plan (D-SNP) unless they opt out; go to the DHS D-SNP webpage (https://dhs.wisconsin.gov/benefit-specialists/d-snp.htm) to learn more.
- **ALS:** If a person has ALS, they will automatically qualify for both Part A and Part B the month their disability benefits begin.

A Medicare card will be mailed as early as three months prior to their 65th birthday or 25th month of disability award.

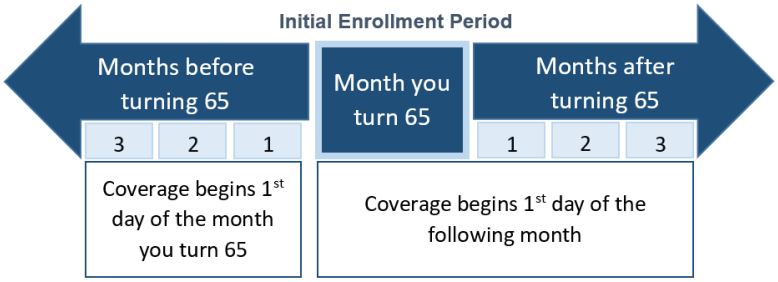
If a person does not want to be enrolled in Part A and/or B, they should follow the instructions that come with the card and send back the form to delay enrollment. Should they keep the card, Medicare Part A and/or B will begin on their eligibility month and premiums will be charged.

Not automatic, action required

- **Age 65:** Not receiving benefits from Social Security or Railroad Retirement Board, that is, people who have not reached their full SSA retirement age, are still working and have employer group health coverage, or are retired employees from certain municipal fields.
  - 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 should sign up for Part A and/or Part B will depend on if they have other health and drug insurance coverage that is "creditable" (considered as good as Medicare).
- **ESRD:** Individuals with ESRD should sign up for Part A and B by visiting their local SSA office or RRB or calling SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Medicare Enrollment Periods

Initial enrollment opportunities

Parts A and B	Part D	Part C	Medigap
Initial Enrollment Period (IEP) Seven-month window surrounding month of entitlement to Medicare during which you can sign up for Medicare			**Medigap Open Enrollment Period** Six-month window after Part B first starts (and, for Medicare due to disability, again when turning 65) You have guaranteed issue rights when applying for a Medigap.
Special Enrollment Period (SEP) Granted in certain situations	**Special Enrollment Period (SEP)** Granted by Medicare in certain situations	**Special Enrollment Period (SEP)** Granted by Medicare in certain situations	
General Enrollment Period (GEP) Jan. 1–March 31 (effective next month)	**If you use GEP *and* don't already have Part A: You can sign up for Part D** April 1–June 30 (effective July 1)	**If you use GEP: You can sign up for Part C** Three months before Part B starts (effective same date as Part B)	

Opportunities to change coverage

Parts A and B	Part D	Part C	Medigap
N/A	**Medicare Annual Open Enrollment Period (OEP)** for Parts C and D: Oct. 15–Dec. 7 You can change Part C or D. (effective Jan. 1)		You can apply for a new or different Medigap at any time, but you may be denied or subject to: • Higher premiums • Underwriting (waiting period for coverage of pre-existing conditions for up to six months)
	N/A	**Medicare Advantage Open Enrollment Period (MA-OEP)** Jan. 1–March 31 You must already be enrolled in an MA plan. You can make one change: Switch your MA plan *or* return to Original Medicare and enroll in Part D	

Note: If you go without creditable coverage (health insurance that's as good as Medicare), Medicare coverage may be delayed and late enrollment penalties may apply.

Note: Health savings accounts (HSAs)

If you sign up for Medicare:	During your IEP Two months after your IEP ends	You can avoid a tax penalty by making your last HSA contribution the month before you turn 65.
If you wait to sign up for Medicare:	Less than six months after you turn 65	You can avoid a tax penalty by stopping HSA contributions the month before you turn 65.
	Six or more months after you turn 65	You can avoid a tax penalty by stopping HSA contributions six months before the month you apply for Medicare.

References: Medicare and You Handbook; Medicare.gov

2025 Original Medicare Costs
(Without Medigap or secondary coverage)

Part A	**You pay**
Benefit period deductible covering the first 60 days of Medicare-covered inpatient hospital care in a benefit period	$1,676
Inpatient hospital care copays	
Days 61–90 in a benefit period	$419 per day
Days 91–150 (lifetime reserve) in a benefit period	$838 per day
Days 151+ in a benefit period	All costs
Skilled nursing facility (SNF) copays	
Days 1–20 in a benefit period	$0
Days 21–100 in a benefit period	$209.50 per day
Monthly premium*	
For beneficiaries with **40 quarters** of coverage	$0
For beneficiaries with **30–39 quarters** of coverage	$285
For beneficiaries with **less than 30 quarters** of coverage	$518
Part B	**You pay**
Monthly premium	$185**
Annual deductible	$257
Part B coinsurance	20%
If the Part B provider doesn't **accept assignment**, they can bill **excess charges.**	Up to 15%

***A divorced spouse may be able to apply for Medicare benefits on the work record of their former spouse.

****The hold harmless provision prevents the Part B premium from increasing more than the annual increase for the Social Security benefit payments for certain individuals.

Medicare beneficiaries with ESRD who received a kidney transplant 36 months ago can continue Part B coverage of immunosuppressive drugs by paying a $103 monthly premium (+ any IRMAA).

References: CMS Newsroom Press Releases; NCOA Open Enrollment Toolkit; Medicare Rights Center: Hold Harmless; Medicare.gov; federal register

2025 Original Medicare Part A (Hospital) (Without Medigap or secondary coverage)

Service	Benefit	You pay (Per benefit period*)	Medicare pays
Inpatient hospitalization* Semi–private room and board, general nursing, inpatient drugs, and miscellaneous hospital services and supplies	First 60 days	$1,676	All but $1,676
	61st to 90th day	$419 per day	All but $419 per day
	Lifetime reserve days		
	91st to 150th day (these 60 reserve days may be used only once in your lifetime)	$838 per day	All but $838 per day
	Beyond 150 days	All costs	Nothing
Skilled nursing facility (SNF) care** Custodial care not covered	First 20 days	Nothing	Full cost of services
	21st through 100th day	$209.50 per day	All but $209.50 per day
	Beyond 100 days	All costs	Nothing
Home health care After a covered inpatient hospital stay; up to 100 visits	Visits limited to medically necessary part-time skilled care of a homebound individual	Nothing	Full cost of services (see durable medical equipment)
Hospice care Available to terminally ill	Unlimited renewable benefit period	$5 for each outpatient prescription drug and 5% of Medicare-approved amount for respite care	All but limited costs for outpatient drugs and inpatient respite care

*A new Part A benefit period begins after being home for 60 consecutive days.

You must be hospitalized under Part A as an inpatient for at least **three consecutive days for the same illness prior to admission to the Medicare-approved SNF.

References: CMS Newsroom; Medicare.gov Hospice Care

2025 Original Medicare Part B (Medical)
(Without Medigap or secondary coverage)

Service	Benefit	You pay	Medicare pays
Medical expenses	Physician's services, some diagnostic tests, physical and speech therapy, ambulance, etc.	$257 annual deductible* plus 20% of approved amount**	80% of approved amount (after $257 deductible)
Home health care	Visits limited to medically necessary part-time skilled care of a homebound individual	Nothing	Full cost of services (see durable medical equipment)
Outpatient hospital services	Medically necessary treatment such as outpatient surgery, diagnostic procedures, or emergency room visits	$257 annual deductible* plus copayment or coinsurance for each procedure	A set amount for each specific procedure
Durable medical equipment (DME)	Medically necessary equipment and supplies such as walkers, wheelchairs, or hospital beds	$257 annual deductible* plus 20% of approved amount**	80% of approved amount (after $257 deductible)

*After paying $257 for covered Part B services, the Part B deductible is met for the rest of the calendar year.

**If the doctor is not a "participating provider" who "accepts assignment," meaning they accept Medicare's approved amount as payment in full, then you can be charged an additional 15% of the Medicare-approved amount.

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

- Reference: CMS Newsroom

2025 Wisconsin Medigap Coverage Chart: Comprehensive

	Type of Medigap policy	High deductible	25% cost sharing	50% cost sharing	Basic
	High deductible amount	$2,870	N/A	N/A	N/A
	Out-of-pocket limit	N/A	$3,610	$7,220	N/A
Basic benefits	Kidney disease	√	√	√	√
	Diabetes care	√	√	√	√
	Chiropractic care	√	√	√	√
	Three pints of blood	√	√	√	√
	Anesthesia for dental	√	√	√	√
	Breast reconstruction	√	√	√	√
	Colorectal cancer screening	√	√	√	√
	Cancer clinical trials	√	√	√	√
Part A	Deductible: $1,676	√	25%	50%	R (50%/100%)
	Inpatient copays: ≥$419/day	√	√	√	√
	Skilled nursing facility (SNF) copay: $209.50/day	√	√	√	√
	Inpatient mental health stay: 175 days/lifetime	√	√	√	√
	Hospice copay/coinsurance	√	25%	50%	√
A/B	Home health: 40 extra visits	√	√	√	√
	Home health: 365 visits total	√	R	R	R
Part B	Deductible: $257*	√*	5% up to $3,610	10% up to $7,220	R*
	Coinsurance: 20%	√			R
	Excess charges: 15%	√			R
Other	Non-Medicare SNF: 30 days	√	√	√	√
	Foreign travel emergency (limits apply)	√			R

√ = Always covered; R = Optional rider

* Medigap coverage of the Part B deductible is not available to people who are eligible for Medicare (not necessarily enrolled) on or after Jan. 1, 2020.

References: OCI's Guide to Health Insurance for People with Medicare in Wisconsin; Medicare.gov; CMS.gov Deductible Announcements; CMS.gov Out-of-Pocket Limits Announcements; NCOA

2025 Wisconsin Medigap Coverage Chart: Condensed

(Policy differences only)

Type of Medigap policy	High deductible	25% cost sharing	50% cost sharing	Basic
High deductible amount	$2,870	N/A	N/A	N/A
Out-of-pocket limit	N/A	$3,610	$7,220	N/A
Part A deductible: $1,676	√	25%	50%	R (50%/100%)
Part A hospice copay/coinsurance	√	25%	50%	√
Home health: 365 visits total	√	R	R	R
Part B deductible: $257*	√*			R*
Part B coinsurance: 20%	√	5% up to $3,610	10% up to $7,220	R
Part B excess charges: 15%	√			R
Foreign travel emergency (limits apply)	√			R

√ = Always covered

R = Optional rider

* Medigap coverage of the Part B deductible is not available to people who are new to Medicare on or after Jan. 1, 2020.

Note that one must have only been Medicare *eligible*, not necessarily enrolled, before Jan. 1, 2020.

References: OCI's Guide to Health Insurance for People with Medicare in Wisconsin; Medicare.gov; CMS.gov Deductible Announcements; CMS.gov Out-of-Pocket Limits Announcements; NCOA

Medicare Supplement (Medigap) Enrollment

What are Medigaps

Medigap policies, sold by private insurance companies, help pay some of the health care costs that Medicare Parts A and B don't cover. Policies have a monthly premium.

Medigap Open Enrollment Period

- What: Gives a guaranteed right to buy any Medigap policy sold in-state

  The issuing company may impose a pre-existing condition waiting period (six months maximum) unless the beneficiary has had "creditable" and "continuous" coverage (no break in coverage of more than 63 days).
- When: six-month period that starts the first month they're (a) under 65 and qualify for Medicare due to disability and enrolled in Part B, and/or (b) at least 65 and enrolled in Part B

  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.

Guaranteed issue rights

- What: 63-day protected time to buy a Medigap policy, regardless of health status, after a qualifying event
- When: A comprehensive list of qualifying events is in the "Guaranteed Issue" section of OCI's Guide to Health Insurance for People with Medicare in Wisconsin, including:
  - The beneficiary loses Medicaid.
  - The beneficiary moves outside the plan's service area.
  - The plan discontinues or leaves the service area.
  - The beneficiary exercises Medicare Advantage trial rights when they:
    - Enroll in a Medicare Advantage plan or a Medicare Cost plan after first becoming eligible for Medicare Parts A and B at age 65, then decide to return to Original Medicare within the first 12 months of enrollment.
    - Terminate an employer group plan to enroll in a Medicare Advantage plan, then disenroll from the Medicare Advantage plan during a federal enrollment period within the first 12 months of coverage in the Medicare Advantage plan.
    - Drop a Medigap policy to join a Medicare Advantage plan or Medicare Cost plan, or to buy a Medicare SELECT policy for the first time, and then leave the plan or policy within one year after joining (guaranteed issue only for the original Medigap policy; if that's not still available, then for any policy).

Purchasing a Medigap policy after the Medigap open enrollment period or without guaranteed issue rights

A person can try to purchase or change Medigap policies at any time, but insurance companies can:

- Deny coverage.
- Charge higher premiums.
- Impose waiting periods for coverage of pre-existing conditions for up to six months.

For higher income individuals			
2025 Part B IRMAA (Income-Related Monthly Adjustment Amount)			
If your 2023 annual income is:		In 2025 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 (per person)
$106,000 or less	$212,000 or less	$0	$185
Above $106,000 and up to $133,000	Above $212,000 and up to $266,000	$74	$259
Above $133,000 and up to $167,000	Above $266,000 and up to $334,000	$185	$370
Above $167,000 and up to $200,000	Above $334,000 and up to $400,000	$295.90	$480.90
Above $200,000 and less than $500,000	Above $400,000 and less than $750,000	$406.90	$591.90
$500,000 or more	$750,000 or more	$443.90	$628.90
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
$106,000 or less		$0	$185
Above $106,000 and less than $394,000		$406.90	$591.90
$394,000 or more		$443.90	$628.90
Beneficiaries with ESRD who pay a Part B premium to continue coverage of immunosuppressive drugs should consult CMS.gov to view IRMAA costs.			
Reference: Medicare.gov; CMS Newsroom			

For higher income individuals

2025 Part D IRMAA (Income Related Monthly Adjustment Amount)

If your 2023 annual income is:		In 2025 you pay:
Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Income-related monthly adjustment amount
$106,000 or less	$212,000 or less	$0.00 + plan premium
Above $106,000 and up to $133,000	Above $212,000 and up to $266,000	$13.70 + plan premium
Above $133,000 and up to $167,000	Above $266,000 and up to $334,000	$35.30 + plan premium
Above $167,000 and up to $200,000	Above $334,000 and up to $400,000	$57.00 + plan premium
Above $200,000 and less than $500,000	Above $400,000 and less than $750,000	$78.60 + plan premium
$500,000 or more	$750,000 or more	$85.80 + plan premium
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
$106,000 or less		$0 + plan premium
Above $106,000 and less than $394,000		$78.60 + plan premium
$394,000 or more		$85.80 + plan premium

Reference: Medicare.gov; CMS Newsroom

2025 Part D Standard Coverage and Costs

Medicare Part D covers prescription drug costs. Standalone Part D plans (PDPs) offered by private companies coordinate with Original Medicare. Medicare Advantage plans also can offer prescription coverage (MA-PDs). This table covers costs for standalone Part D plans.

The cost of your drugs depends on your Part D plan, your pharmacy, your drug, and what Part D coverage phase you are in. The Part D coverage phases change based on how much you've spent out of pocket and are explained below.

Coverage phase	**1. Deductible**	**2. Initial**	**3. Catastrophic**
You pay	**≤$590**	**≤$2,000**	**$0**
Explanation	You pay the full cost of your prescriptions until the deductible is reached.	You pay 25% of your prescription costs until you reach the $2,000 max.	You do not pay anything for your prescriptions.
Exceptions	Not all plans charge a deductible. In some plans, preferred generics are not subject to the deductible.	In the PlanFinder, you may see $0 costs for drugs before hitting the $2,000 limit. This is because your true out-of-pocket costs (TrOOP) totaled $2,000. The IRA allows enhanced alternative (EA) Part D plan costs to be counted.	N/A
Late enrollment penalty	In addition to your prescription costs, you pay a monthly premium for your Part D plan. If you went without creditable coverage, you may be charged a Part D late enrollment penalty. The penalty is a permanent Part D premium increase; the exact amount changes each year. The penalty calculation is 1% of the Part D national base premium ($36.78 in 2025) multiplied by the number of months without creditable drug coverage.		
References	Medicare.gov Part D late enrollment penalty; NCOA Part D Graphic; NCOA Part D Cost Sharing Chart; Understanding True Out-of-Pocket Costs (TrOOP) (CMS 11223-P)		

Medicare Prescription Payment Plan (M3P) Option

What is this payment option?
This is an *optional* payment plan to "smooth" your Part D prescription costs over the course of the calendar year.

It does *not* save you money; it only changes *when* you pay for your prescriptions.

Who can participate?
Anyone with Part D can participate, including people with a standalone Part D plan (PDP) or Medicare Advantage prescription drug plan (MA-PD).

Who will benefit?
You will most likely benefit if you:

- Have a one-time drug cost that's $600 or more.
- Enroll in the beginning of the year.

How do I pay for my prescriptions using this option?
Instead of paying for your drugs at the pharmacy, you'll get a bill each month from your Part D plan.

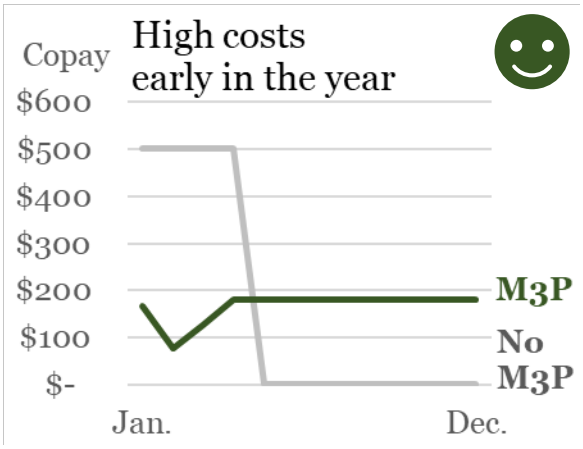
How do I know what my bill would be?
Your bill could change each month. It's calculated based on incurred costs divided by the number of months left in the year.

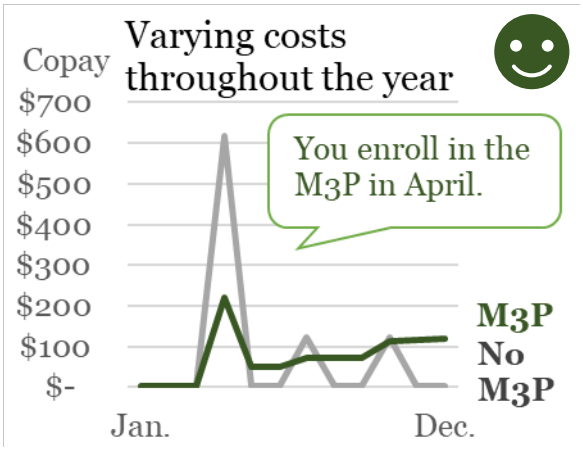
You would never pay more than the total amount you would have paid to a pharmacy nor more than the $2,000 annual out-of-pocket maximum.

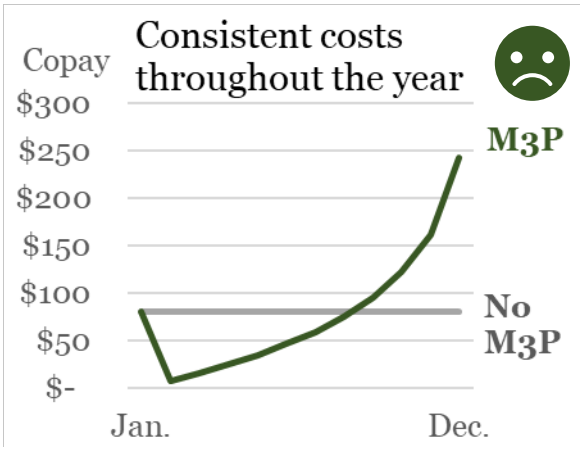
The Medicare.gov Plan Finder tool can estimate costs using this payment option.

How do I enroll?
Contact your Part D plan to enroll.

What if I miss my payments?
Your plan will send you a reminder. If you miss your payment after the reminder deadline, you will be disenrolled from the Medicare Prescription Payment Plan *but not your Part D plan*. You would still owe the balance. The Part D plan *cannot* charge interest or late fees; however, they can send your bill to collections.







Can I change my mind?
Yes. You can disenroll at any time by contacting your plan. You must pay your remaining balance; you can do so all at once or be billed monthly. Moving forward, you would pay for any future prescriptions at the pharmacy counter.

If you change Part D plans, your enrollment in the Medicare Prescription Payment Plan will end. To re-enroll, you would need to contact your new plan.

References: https://www.medicare.gov/prescription-payment-plan; What's the Medicare Prescription Payment Plan?(CMS 12211)

2025 SeniorCare

- SeniorCare is a prescription drug assistance program that covers most generic and brand name drugs and over-the-counter insulin. Vaccines are covered at no cost.
- SeniorCare is considered creditable coverage for Medicare Part D. Beneficiaries can have SeniorCare *and* a Part D plan; SeniorCare will coordinate coverage with the other plan.

Non-financial eligibility	• Wisconsin resident • U.S. citizen or have qualifying immigrant status • At least 65 years old • Not enrolled in Medicaid

Income		**Coverage (per person)**	
Level	**Annual income limit**	**Deductible**	**Out-of-pocket costs for covered drugs**
1	≤$25,040 individual ≤$33,840 couple [≤160% federal poverty level (FPL)]	None	• $5 copay for each generic drug • $15 copay for each brand name drug • $0 for vaccines
2A	$25,041–$31,300 individual $33,841–$42,300 couple (160%–200% FPL)	$500	• Pay the SeniorCare rate for drugs until the $500 deductible is met. • After $500 deductible is met, pay a $5 copay for each generic drug and a $15 copay for each brand name drug. • $0 for vaccines
2B	$31,301–$37,560 individual $42,301–$50,760 couple (200%–240% FPL)	$850	• Pay the SeniorCare rate for covered drugs until the $850 deductible is met. • After $850 deductible is met, pay a $5 copay for each generic drug and a $15 copay for each brand name drug. • $0 for vaccines
3	$37,561+ individual $50,761+ couple (≥240% FPL)	$850 after spend-down	• Pay retail price for covered drugs during spenddown (the difference between gross annual income and 240% FPL). • After the spenddown is met, meet the deductible. • Pay the SeniorCare rate for covered drugs until the $850 deductible is met. • After $850 deductible is met, pay a $5 copay for each generic drug and a $15 copay for each brand name drug. • $0 for vaccines

Enrollment and renewal

- **Fees**: $30 annual fee for all participants
- **Timing**: The earliest you can apply is during the calendar month of your 65th birthday. If you are already age 65 or older, you can apply at any time.
- **Effective date**: The month after you apply
- **How to apply**: Call SeniorCare Customer Service at 800-657-2038 (TTY 711), or download F-10076

References: DHS SeniorCare Publications: Information about SeniorCare (P-10078); DMS Operations Memo 24-02

2025 Part D Extra Help [Low Income Subsidy (LIS)]

Beneficiaries with low income and assets can qualify for help with their Medicare drug costs through the Extra Help program, also known as the Low Income Subsidy (LIS).

Eligibility

Automatically eligible	Receive SSI, Medicare Savings Program (MSP), or full Medicaid		
Financially eligible	**Household size**	**Income** (150% FPL)	**Assets** (excluding $1,500 burial funds)
Apply through Social Security: online, phone, or request a paper app.	1	$1,903	$16,100
	2	$2,575	$32,130

Benefits and costs

Premiums: Extra Help helps pay the Part D plan premium.

"Benchmark plan" premiums will be $0 for people with Extra Help.

Copays during the Part D coverage phases:**

LIS recipients do not pay a deductible. They may need to pay small copays for their drugs until their total drug costs reach the catastrophic coverage period threshold.

Initial coverage Until costs reach $2,000	Category 1: Full Medicaid with income between 100-150% FPL *or* MSP-only	Category 2: Full Medicaid with income up to or at 100% FPL	Category 3: Receive home and community-based services (HCBS) or institutional Medicaid
	$4.90 generics $12.15 brand name	$1.60 generics $4.80 brand name	$0
Catastrophic	$0		

** Pharmacies may charge for bubble packaging of medication.

Duration of coverage

If someone loses of Extra Help eligibility:

- Before July 1: keep Extra Help for the remainder of the calendar year
- Between July – December: keep Extra Help for the rest of the calendar year and the entire following calendar year

References: NCOA LIS Eligibility Chart; HHS.gov Federal Poverty Level Guidelines (FPL); POMS; Medicare Interactive; CY2025 Rate Announcement; (CY) 2025 Resource and Cost-Sharing Limits for LIS; POMS HI 03001.005

2025 Medicare Savings Programs (MSP)

- The Medicare Savings Program (MSP) is a state Medicaid program that can help pay Medicare health premiums and possibly other costs. Medicare beneficiaries with SSI or certain Medicaid programs automatically get MSP. Others who qualify can apply at access.wi.gov.
- It may take two months for payments to begin; refunds will be backdated to the effective date.

Programs	Non-financial eligibility	Monthly income limits	Asset limits	Program pays	Effective date
Qualified Medicare Beneficiary **(QMB)**	Entitled to Part A	$1,304.17 individual $1,762.50 couple (100% FPL)	$9,660 individual $14,470 couple	Parts A and B premiums, deductibles, and coinsurance	First day of the month after the application is approved
Specified Low-Income Medicare Beneficiary **(SLMB)**	Entitled to Part A	$1,565.00 individual $2,115.00 couple (120% FPL)	$9,660 individual $14,470 couple	Part B premiums	Up to three months prior to application date
Specified Low-Income Medicare Beneficiary Plus **(SLMB+)***	• Entitled to Part A • Not enrolled in full, Family Planning, or Tuberculosis Only Medicaid	$1,760.63 individual $2,379.38 couple (135% FPL)	$9,660 individual $14,470 couple	Part B premiums	Up to three months prior to application date
Qualified Disabled and Working Individual **(QDWI)**	• Entitled to Part A • Disabled and employed • Not enrolled in Medicaid	$2,608.34 individual $3,525.00 couple (200% FPL)	$4,000 individual $6,000 couple	Part B premiums	Up to three months prior to application date

***FYI:** Other states refer to this eligibility category as Qualified Individual (QI), and SLMB+ as eligibility for SLMB *and* full Medicaid.

Note: Medicaid estate recovery is eliminated for MSP per the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

References: Medicare Savings Programs (P-10062) (available in multiple languages); Medicaid Eligibility Handbook 39.4

2025 Medicaid Eligibility

Program* See P-02383 or the DHS website for all programs.	Non-financial eligibility Other eligibility criteria may apply.	Countable monthly income limit	Countable asset limits
BadgerCare Plus	• Non-Medicare, **and** • Age 19–64, **or** • Parents or caretaker relatives of dependent children up to 18 years	$1,304.17 individual $1,762.50 couple (100% FPL)	No limit
BadgerCare Plus	• Non-Medicare, **and** • Pregnant, **or** • Children up to 19 years	$3, 990.76 individual $5, 393.25 couple (306% FPL)	No limit
Elderly, Blind or Disabled (EBD) Categorically Needy	Receiving Supplemental Security Income (SSI)	$1,050.78 individual $1,582.05 couple (SSI limits)	$2,000 individual $3,000 couple
Elderly, Blind or Disabled (EBD) Medically Needy	• Age 65 or older, **or** • Determined blind or disabled by the Disability Determination Bureau (DDB)	$1,304.17** individual $1,762.50** couple (100% FPL)**	$2,000 individual $3,000 couple

**Can have income above the limit and become eligible by meeting a deductible. The deductible period is 6 months long. The deductible is the difference between the household's countable monthly income and the medically needy income limit, times six.

Beneficiaries with BadgerCare+ who become eligible for Medicare will be reassessed for EBD Medicaid eligibility. They will either lose Medicaid or transition to EBD Medicaid.

References: BadgerCare+ Eligibility Handbook; Medicaid Eligibility Handbook; DMS Operations Memo 25-02; DHS Annual Income Limits; SSA.gov; CMS

Who Pays First			
If you...	And your situation is...	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	Group health plan	Medicare
	The employer has 20 or more employees		
	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 is working	Entitled to Medicare	Large group health plan	Medicare
	The employer has 100 or more employees.		
	The employer has less than 100 employees	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 Consolidated Omnibus Budget Reconciliation Act (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			
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	Medicare usually doesn't cover these claims. 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.	Not applicable. Medicare does not pay for claims covered by VA insurance, and vice versa.
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

2025 Original Medicare Part A and B Appeals

Appeal level	Minimum amount*	How to file the appeal	Deadline to request appeal	When to expect a decision
1	None	File appeal using Medicare Summary Notice (MSN) with Medicare administrative contractor (MAC): CGS Administrators	**120 days** after receiving the initial determination on Medicare Summary Notice (MSN)	60 days
2	None	Request reconsideration and provide any additional evidence to qualified independent contractor (QIC)	**180 days** after receiving Medicare Redetermination Notice (MRN)	60 days
3	$190	Request hearing with administrative law judge (ALJ)	**60 days** after receiving qualified independent contractor (QIC) notice of decision, **or** after expiration of the QIC reconsideration timeframe if no decision is received	90 days, but may be delayed due to volume
4	None	Request review from Medicare Appeals Council	**60 days** after receiving ALJ notice of decision, **or** after expiration of the ALJ hearing timeframe if no decision is received	90 days if appealing an ALJ decision, **or** 180 days if ALJ review time expired without a decision
5	$1,900	Request judicial review	**60 days** after receiving notice of Medicare Appeals Council decision, **or** after expiration of the Medicare Appeals Council hearing timeframe if no decision is received	No deadline

*The appeal can only proceed to the next level if the denied service is worth at least the "amount in controversy."

Note: A beneficiary can appoint an authorized representative to file appeals for them.

References: CMS.gov; Medicare.gov

2025 Medicare Advantage (Part C) Appeals: Before Receiving Services

Before appealing, the beneficiary requests coverage of a service from the plan. The plan has 14 days to process a standard request or 72 hours for an expedited request.

If the plan denies coverage and sends a Notice of Denial of Medical Coverage:

Appeal level	Minimum amount*	How to file the appeal	Deadline to request appeal	When to expect a decision	
				Standard appeal	Expedited appeal
1	None	File appeal with plan	60 days	30 days	72 hours
2	None	Send supporting documents to independent review entity (IRE)**	10 days**	30 days	72 hours
3	$190	Request hearing with administrative law judge (ALJ)	60 days	No deadline	
4	None	Request review from Medicare Appeals Council	60 days	No deadline	
5	$1,900	Request judicial review	60 days	No deadline	

*The appeal can only proceed to the next level if the denied service is worth at least the "amount in controversy."

**After upholding the denial, the plan will automatically escalate the appeal to the IRE. After receiving notice that the appeal was sent to the IRE, beneficiaries have 10 days to send the IRE supporting documents (if they wish to).

Note: A beneficiary can appoint an authorized representative to file appeals for them.

References: CMS.gov; Medicare.gov; SHIP TA Center's OCCT Course 3.2 supplemental materials

2025 Medicare Advantage (Part C) Appeals: After Receiving Services or Payment

If the plan denies coverage and sends a Notice of Denial of Medical Coverage:

Appeal level	Minimum amount*	How to file the appeal	Deadline to request appeal	When to expect a decision	
				Standard appeal	Expedited appeal
1	None	File appeal with plan	60 days	60 days	72 hours
2	None	Send supporting documents to independent review entity (IRE)**	10 days**	60 days	72 hours
3	$190	Request hearing with administrative law judge (ALJ)	60 days	No deadline	
4	None	Request review from Medicare Appeals Council	60 days	No deadline	
5	$1,900	Request judicial review	60 days	No deadline	

*The appeal can only proceed to the next level if the denied service is worth at least the "amount in controversy."

**After upholding the denial, the plan will automatically escalate the appeal to the IRE. After receiving notice that the appeal was sent to the IRE, beneficiaries have 10 days to send the IRE supporting documents (if they wish to).

Note: A beneficiary can appoint an authorized representative to file appeals for them.

References: CMS.gov; Medicare.gov; SHIP TA Center's OCCT Course 3.2 supplemental materials

2025 Medicare Appeals: Termination of Facility Coverage

After the beneficiary receives a Notice of Medicare Non-Coverage for termination of coverage at the following types of facilities:

- Skilled nursing facility (SNF)
- Home health agency (HHA)
- Comprehensive outpatient rehabilitation facility (CORF)
- Hospice facility

Appeal level	Minimum amount*	How to file the appeal	Deadline to request appeal	When to expect a decision
1	None	File appeal with beneficiary and family- centered care quality improvement organization (BFCC-QIO): Livanta	**Hospital**	
			Discharge date	Within one day of receiving all information
			Non-hospital facility**	
			By noon of the day that care is set to end	The day that care is set to end
2	None	File appeal with BFCC-QIO: Livanta	60 days	14 days
3	$190	Request hearing with administrative law judge	60 days	90 days
4	None	Request review from Medicare Appeals Council	60 days	90 days
5	$1,900	Request judicial review	60 days	No deadline

*The appeal can only proceed to the next level if the denied service is worth at least the "amount in controversy."

Note: A beneficiary can appoint an authorized representative to file appeals for them.

References: CMS.gov; Medicare.gov; SHIP TA Center's OCCT Course 3.2 supplemental materials

2025 Part D Coverage Appeals

Appeal level	Minimum amount*	How to file the appeal	Deadline to request appeal	Decision deadline	
				Standard	Expedited
Before appealing	None	Request coverage determination from plan**	N/A	72 hours	24 hours
1	None	Request redetermination from plan*	60 days	7 days	72 hours
2	None	File appeal with Independent Review Entity (IRE)	60 days	7 days	72 hours
3	$190	Request hearing with Administrative Law Judge (ALJ)	60 days	90 days	10 days
4	None	Request review from Medicare Appeals Council	60 days	90 days	10 days
5	$1,900	Request judicial review	60 days	No deadline	No deadline

*The appeal can only proceed to the next level if the denied claim is worth at least the "amount in controversy."

**Coverage requests can be for formulary or tiering exceptions.
The beneficiary, their authorized representative, or their doctor or prescriber can file the request.

References: CMS.gov; Medicare.gov; SHIP TA Center's OCCT Course 3.3 Part D Appeals Handout