A Guide to Dental, Vision, and Hearing Coverage for Older Adults and People with Disabilities in Illinois

This guide is intended as a tool for counselors and professionals to use when assisting older adults and people with disabilities living in Illinois to learn more about how Medicare and Medicaid cover dental, vision, and hearing care. It should be used as a starting point to better understand how these benefits are covered by each type of insurance, which services are excluded from coverage, and to explore resources that can be used by beneficiaries, such as financial assistance and charity programs if they are uninsured or underinsured.

Dental, vision, and hearing care can be a costly expense for older adults and people with disabilities on Medicare since coverage for these services is generally excluded under original Medicare. As a result, many older adults and people with disabilities pay out-of-pocket or forgo receiving care for these services which can negatively impact their health and quality of life.

A recent Medicare Current Beneficiary Survey revealed that nearly 75% of Medicare beneficiaries pay out of pocket for dental care. The National Federation of the Blind reports that nearly three million people age 65 and older have a vision difficulty. In addition, one in ten Americans experience hearing loss and 95% of these individuals could be treated with hearing aids, but only 22% use them (according to MarkeTrak, a consumer survey on hearing loss in America). The inability to access these vital services impacts Medicare beneficiaries in more ways than one. Whether it is a beneficiary who is in need of eyeglasses and unable to read prescription bottle labels or a beneficiary who experiences communication barriers and social isolation due to hearing loss.

Professionals who serve beneficiaries in need of dental, vision or hearing services and unable to pay out-of-pocket for them usually have a difficult time locating free or affordable options. Individuals are surprised to learn that Medicare provides very limited or no coverage for these services. Medicaid does provide dental, vision, and hearing care for individuals who qualify, however consumers and professionals often have a difficult time navigating Medicaid to access these benefits, understanding how services are covered, or knowing where to find detailed Medicaid policy that lists what specifically is covered.

Please note this guide does not guarantee that a specific service will be covered and is intended to be used as an educational reference to better understand which services are available. Individuals should always contact any provider prior to receiving care to find out if a dental, vision or hearing service will be covered or to determine if prior authorization is required.

Dental Services

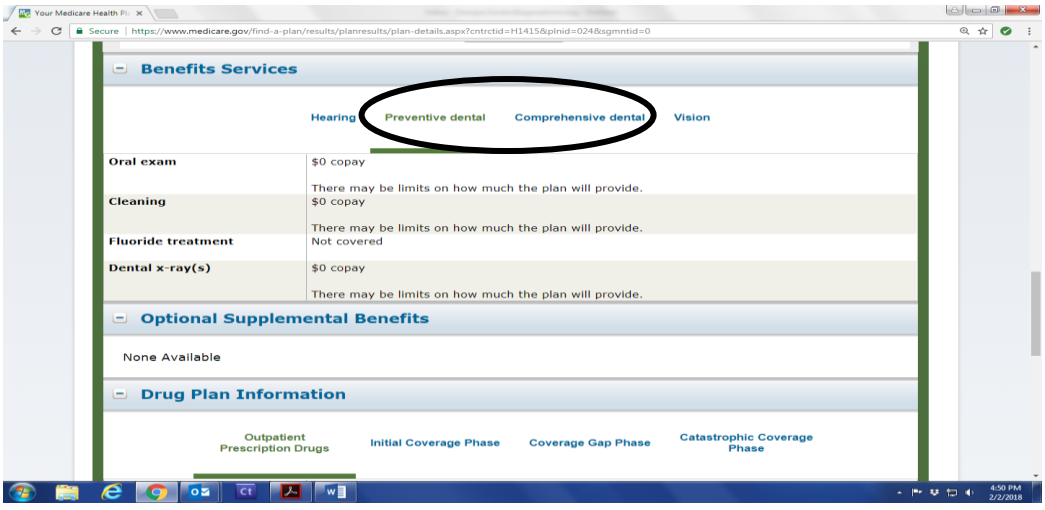
Original Medicare

Most dental benefits are excluded under original Medicare. Medicare does not cover services such as dental cleanings, exams, fillings, procedures or dentures if the only purpose is to maintain and restore a beneficiary's teeth. Medicare will only pay for dental procedures in limited circumstances and that are required as part of a covered procedure due to an underlying medical condition. (For example, dental extractions done in preparation for radiation treatment due to cancer or jaw reconstruction following an accident.) Under certain circumstances, Medicare may also cover oral exams, but not any dental treatment, before kidney transplants or heart valve replacement. Medicare will not cover dental procedures when the dental procedure is the primary service. Beneficiaries with Original Medicare who have also purchased a Medicare Supplement policy (also referred to as a Medigap policy) will only receive coverage for services that are covered under Original Medicare. Medicare Supplement policies do not include coverage of dental benefits.

For more information on the limited circumstances of when Medicare covers dental care, refer to chapter 15 of the Medicare Benefit Policy Manual (see section 150 – dental services).

Medicare Advantage

Medicare Advantage (MA) plans have the option of offering dental services as part of their health benefits package, although it is not required by the Centers for Medicare and Medicaid Services (CMS). If an MA plan offers dental services, these services are typically limited to routine dental care such as cleanings, x-rays, and oral exams. The scope of services vary by MA plan, and beneficiaries should contact a plan directly to learn if a plan provides any dental coverage and the extent of their services. To determine if an MA plan offers dental benefits, beneficiaries can also use the Medicare Plan Finder at www.Medicare.gov. Plans that include dental benefits will display the following symbol: (D) on the Medicare Plan Finder. Please see below for a snapshot of where on the Medicare.gov Plan Finder extra benefits with an MA plan can be located.



Some MA plans may also contract with an insurer or provider to offer their members an optional supplemental dental policy that includes more comprehensive coverage of

non-Medicare covered benefits (such as dental or vision care) up to a certain dollar amount. These optional packages also vary by plan and may include dental, vision, or hearing coverage or all three under one policy. Optional benefit packages usually require the member to pay an extra premium amount each month in addition to any Medicare Advantage and Part B premium the beneficiary already pays. Beneficiaries can find out if a plan offers these types of packages by contacting the plan directly or visiting the Medicare Plan Finder.

Medicaid (Fee-For-Service) in Illinois

What is the HFS Dental Program?

The Illinois Department of Healthcare and Family Services (HFS) Dental Program provides coverage of restorative dental benefits to adults age 21 and older. (Medicaid also provides dental services to children, but this guide only reviews coverage for individuals age 21 or older.)

HFS has contracted with DentaQuest of Illinois, LLC to administer dental benefits to adults who are enrolled in fee-for-service Medicaid. Individuals in fee-for-service Medicaid can use their HFS medical card to access dental benefits. In order for services to be covered, the dental provider must be a participating Medicaid provider and enrolled in the DentaQuest program.

What dental services does Medicaid cover?

Medicaid dental benefits include oral exams, cleanings, x-rays, restorative work such as fillings and crowns, select endodontic services such as root canals, extractions, dentures, and additional services. Services provided by a non-Medicaid participating dentist, cosmetic dental work, and routine oral exams for adults age 21 and older are not covered by Medicaid. For a comprehensive list of covered adult dental services, see the DentaQuest Dental Office reference Manual here (see page 106 of the 2017 manual). Effective July 1, 2018, Medicaid will include diagnostic and preventive services as a covered benefit for adults 21 years of age and older. This includes an oral exam and cleaning once per year.

Beneficiaries should always confirm that Medicaid will cover a procedure or service with their participating dental provider before the service is performed. Providers are not allowed to seek reimbursement from individuals for Medicaid covered services. A provider may only bill the beneficiary for a non-covered Medicaid service if there was a written agreement between the provider and the beneficiary prior to the beneficiary receiving a service. The written agreement must state which service will be provided, that the service will not be paid for by Medicaid and that the beneficiary will be financially liable (see section 2.04 of the DentaQuest Reference Manual).

Note, that although Medicaid covers dental care, some procedures and services require prior authorization in order for the service to be covered. In addition, coverage of services may be limited to specific teeth. If prior authorization is required for a certain procedure, the provider should submit supporting documentation in order for DentaQuest to determine if the service is medically necessary or if there is a less expensive option. In addition, Medicaid may limit how many times a service is performed on the same tooth within specified time frames (for ex., root canals are covered at one root canal per tooth, per lifetime). For a list of services covered and by frequency, please see a fact sheet created by EverThrive Illinois.

How much do dental services cost?

Adults age 21 and older on Medicaid are responsible for co-payments for services, however, it is up to the dental provider to choose if they collect the co-payment from the patient. As of 2017, dental co-payments are $3.90 for each dental visit (see page 112 of the DentaQuest Office Reference Manual).

A complete detailed listing of Medicaid covered dental benefits, including which services require prior authorization, who qualifies, and which teeth are covered, can be found by visiting the DentaQuest Manual (see Exhibit B pages 146-165 for services covered for adults Age 21 and older). Please note this reference manual is intended to serve as a manual for Medicaid dental providers and not consumers. A DentaQuest Member Handbook for consumers is located here.

What if prior authorization for a service is denied?

If prior authorization for a service is denied by DentaQuest, the beneficiary has the right to appeal within 60 days of receiving the denial notice. To file an appeal, beneficiaries can call the Fair Hearing Section at 1-855-418-4421, fax 1-312-793-2005, or in writing at: HFS, Bureau of Administrative Hearings 401 South Clinton Street, 6th floor Chicago, IL 60607.

Beneficiaries may also submit complaints regarding the quality of care they receive (not related to denial due to prior authorization, reduction or termination of dental services) by calling DentaQuest at 1-888-281-2076. Complaints may include an issue with the care they received from a participating dentist, the quality of dental care, or denial of access to dental services.

How do I find a dentist that accepts Medicaid?

Individuals enrolled in fee-for-service Medicaid do not need a referral from their primary care physician for dental services. To locate a participating Medicaid dentist and find out if they are accepting new patients, individuals can contact DentaQuest by calling 1-888-286-2447 for a referral. Individuals can also visit the DentaQuest website to locate a dentist by geographic location: http://www.dentaquest.com/state-plans/regions/illinois/.

Medicaid Managed Care Plans (MMAI and Health Choice Illinois plans)

Medicaid Managed Care Organizations (MCOs) are responsible for managing and providing dental benefits for Medicaid eligible individuals enrolled in their plans, along with their other health care benefits. Some MCOs have subcontracted with other dental administration companies besides DentaQuest to manage the dental portion of their plan to their members. For a complete listing of MCO Dental Administrators by plan, visit https://www.illinois.gov/hfs/MedicalClients/dental/Pages/DentalManagedCareInformation.aspx.

MCOs are required to provide almost all services offered under fee-for-service Illinois Medicaid, including dental services. Individuals in Medicaid managed care plans usually need to visit a dental provider who is in the plan's network in order for the service to be covered by the plan. Some Medicaid managed care plans also offer extra dental benefits beyond what fee-for-serve Medicaid covers such as additional preventive dental exams and cleanings or comprehensive care.

Medicaid Managed Care plans provide dental coverage but may require prior authorization from the plan for specific services. If a prior authorizations request is denied by a plan, the member has to right to submit an appeal verbally or in writing by contacting their health plan directly within 60 days of receiving the denial. Once the member submits the appeal, the plan has 30 days to make a decision. Members may also request a State Fair Hearing with an impartial hearing officer within 30 days of receiving a decision notice from their plan. For more information about requesting a State Fair Hearing, visit https://www.illinois.gov/hfs/SiteCollectionDocuments/MCOGrievanceAndAppealsProcess.pdf.

To compare MCOs in Illinois and each plan's dental benefits, visit the HFS website at https://enrollhfs.illinois.gov/choose/compare-plans or contact an MCO directly for additional information.

Resources for Individuals without Dental Insurance or Coverage

Services may be available to help individuals in need of dental care, but without dental insurance. Please note that services are not guaranteed and are listed as a resource that may assist uninsured or underinsured individuals to access dental care.

Schools of Dentistry

University of Illinois at Chicago (UIC) College of Dentistry
The UIC College of Dentistry provides general and specialized dental care at a reduced fee schedule and accepts Medicaid and other dental insurance. For more information or to make an appointment, contact 312-996-1265. To see a list of the different dental and oral care services offered please visit their website at http://hospital.uillinois.edu/primary-and-specialty-care/dentistry.

Advocate Illinois Masonic Dental Residency Program
Advocate Illinois Masonic provides a Mobile Dentistry Program for senior citizens, people with disabilities, individuals who are homeless, school children and others with difficulties accessing adequate dental treatment because of barriers like transportation issues or financial hardships. For more information about the Mobile Dentistry program visit https://www.advocatehealth.com/immc/health-services/dentistry/programs.

Advocate also provides a Special Dental Care Program that provides dental services to individuals with developmental disabilities. Contact 773-871-2188 to learn more about the program, including eligibility requirements.

Southern Illinois University (SIU) School of Dentistry
SIU School of Dentistry provides dental care by a student or resident under the supervision of experienced faculty. The school has three locations in Alton, East St. Louis, and Edwardsville. Services are provided to patients at a reduced fee and individuals must be assessed to determine eligibility. The school does accept Medicaid and other dental insurances. For more information visit http://www.siue.edu/dental/patients/index.shtml or contact 888-328-5168, extension 7000.

Midwestern University Dental Institute
Midwestern University is located in Downers Grove and provides dental care at reduced fees. Individuals are assessed to determine if the school is able to provide the type of care needed by the patient. For more information visit https://www.mwuclinics.com/arizona/services/dental/patient-information or call 623-537-6000.

Dental and Health Clinics

Dental Clinics offer reduced cost or sliding scale dental care. “Sliding scale” means that fees and cost of services are based on the individual’s annual income and family size. For a list of dental clinics in Illinois compiled by the IFLOSS Coalition, a group of community organizations dedicated to improving the oral health of Illinois residents, visit the following website: http://ifloss.org/pdf/clinicslist_2011.pdf.

Community dental clinics provide individuals with limited incomes dental care for free or at a reduced cost. The range of services provided may vary by clinic and each clinic has its own eligibility criteria. Clinics may serve specific geographic areas or populations (i.e., children, pregnant women, diabetics, seniors, etc.). Individuals should contact a clinic directly for more information. To view a list of clinics in the Chicagoland area visit the Chicago Dental Society. To search for dental clinics throughout the state of Illinois visit http://www.freedentalcare.us/st/illinois.

Cook County Health and Hospital System
The Dr. Jorge Prieto Health Center offers a dental clinic as part of the Cook County Health and Hospital System. The dental clinic offers Cook County residents with limited incomes dental services including cleanings and fillings, root canals, dentures, crowns and minor oral surgery. For more information, please call the Dr. Jorge Prieto Health Center at 773-257-8301 or visit them at 2424 S. Pulaski Rd., Chicago, IL 60623.

Community Health is a patient-centered medical facility that provides health care at no cost to low income or uninsured individuals. For dental services, an individual must be registered as a Community Health member and should be aware that there is an 8-12 month waiting period. Services are free and include cleanings, fillings, and extractions. To qualify, individuals must not have health insurance of any kind and their income cannot exceed 250% of the Federal Poverty Level (FPL) Guidelines. To view the 2018 FPL guidelines, visit https://aspe.hhs.gov/poverty-guidelines. For more information on how to become a member, visit http://www.communityhealth.org/ or call 773-969-5924.

Additional Dental Care Programs and Resources

The Dental Lifeline Network is a dental not-profit committed to helping older adults, people with disabilities, and the medically fragile. In Illinois, the organization offers the Donated Dental Services program which enlists a network of dentists who have volunteered to provide services at a reduced or no cost. For more information visit http://dentallifeline.org/illinois.

The Illinois State Dental Society is a membership of dental professionals statewide dedicated to promoting oral health care throughout the state of Illinois through communication, education, and legislation. Their website also provides information for the public, including how to locate a dentist or dental clinic. For more information, visit http://www.isds.org.

Community and Economic Development Association (CEDA) offers an Emergency Dental Care Program for individuals who have little or no dental coverage. To qualify for assistance, an individual must live in suburban Cook County, meet the income guidelines, complete an application, and receive services from a participating dentist. For more information visit, http://www.cedaorg.net/www2/Assets/CSBGDental/csbgflyer_dental.pdf and http://www.cedaorg.net/www2/Assets/CSBGDental/ProviderGuide.pdf.

EverThrive has created a tip sheet that provides an overview of Medicaid dental coverage, which services are covered, and additional resources for uninsured individuals that are in need of dental services. http://www.everthriveil.org/sites/default/files/memos-factsheets/attachments/Dental%20Fact%20Sheet%2010%207%2015.pdf.

Medicaid Spenddown may be an option for individuals who are in need of dental care and have limited access to services. Individuals who are over the income and/or asset standards for AABD (Aid to the Aged, Blind, or Disabled) Medicaid have the option to "Spenddown" to qualify for Medicaid. Individuals who can provide Medicaid with paid or unpaid medical bills and expenses that equal their Medicaid Spenddown amount, can qualify for Medicaid even though their income and/or assets may exceed the limits. The Spenddown amount depends on an individual's income and/or assets and is determined by Medicaid.

An individual must meet their spenddown amount each month to qualify for Medicaid for that month. For example, John's Medicaid Spenddown amount is $100 each month. He submitted $200 in medical bills to Medicaid and qualified for two months of Medicaid benefits. John can use Medicaid during the two months he qualifies to receive Medicaid covered dental service. Individuals who utilize Spenddown specifically and for the sole purpose of receiving dental coverage, should make sure Medicaid covers the dental service they need prior to beginning the Medicaid Spenddown process. To learn more about how Medicaid Spenddown works, visit http://www.ageoptions.org/services-and-programs_MMW-MedicaidandManagedCare.html and https://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Brochures/Pages/HFS591SP.aspx.

Vision Services

Original Medicare

Medicare typically does not cover routine vision services such as eye exams, eyeglasses or contact lenses, but does provide some coverage for vision care due to problems associated with eye disease or for certain beneficiaries who are at risk. Medicare covers the following vision services:

- Cataract surgery - Medicare Part A or Part B covers cataract surgery depending on if the surgery is done as in an inpatient or outpatient. A beneficiary should consult with the medical provider performing the surgery to determine their cost sharing amount.
- After cataract surgery with an intraocular lens – Medicare Part B covers one pair of eyeglasses or contact lenses after each cataract surgery that implants an intraocular lens. The beneficiary is responsible for 20% of the Medicare-approved amount once the Part B deductible is met. Beneficiaries must also use a durable medical equipment supplier that is contracted with Medicare in order for the eyeglasses or contact lenses to be covered.
- Macular degeneration – Medicare Part B covers diagnostic tests and some treatment, including injectable drugs, for beneficiaries who have age-related macular degeneration. Beneficiaries are responsible for 20% of the Medicare-approved amount once the Part B deductible has been met.
- Glaucoma screening – Medicare provides coverage for a glaucoma screening once every twelve months for beneficiaries at high risk. Beneficiaries are considered high risk if they have diabetes, a family history of glaucoma, are African American and age 50 or older, or Hispanic and age 65 or older. The screening is covered under Part B and the beneficiary is responsible for paying 20% of the Medicare-approved amount once the annual Part B deductible has been met. If the screening is done in a hospital outpatient setting, the beneficiary must also pay the hospital a co-pay.
- Diabetic retinopathy (for beneficiaries with diabetes) – Medicare covers a yearly eye exam for diabetic retinopathy (an eye disease that can affect diabetics). All Medicare beneficiaries with diabetes are eligible to receive the exam and they pay 20% of the Medicare-approved amount once the annual Part B deductible is met.

It is important that if a specific vision service is recommended to a Medicare beneficiary, that the beneficiary consults with their provider and confirm with Medicare that they are eligible to receive the service and how much they will be responsible for paying.

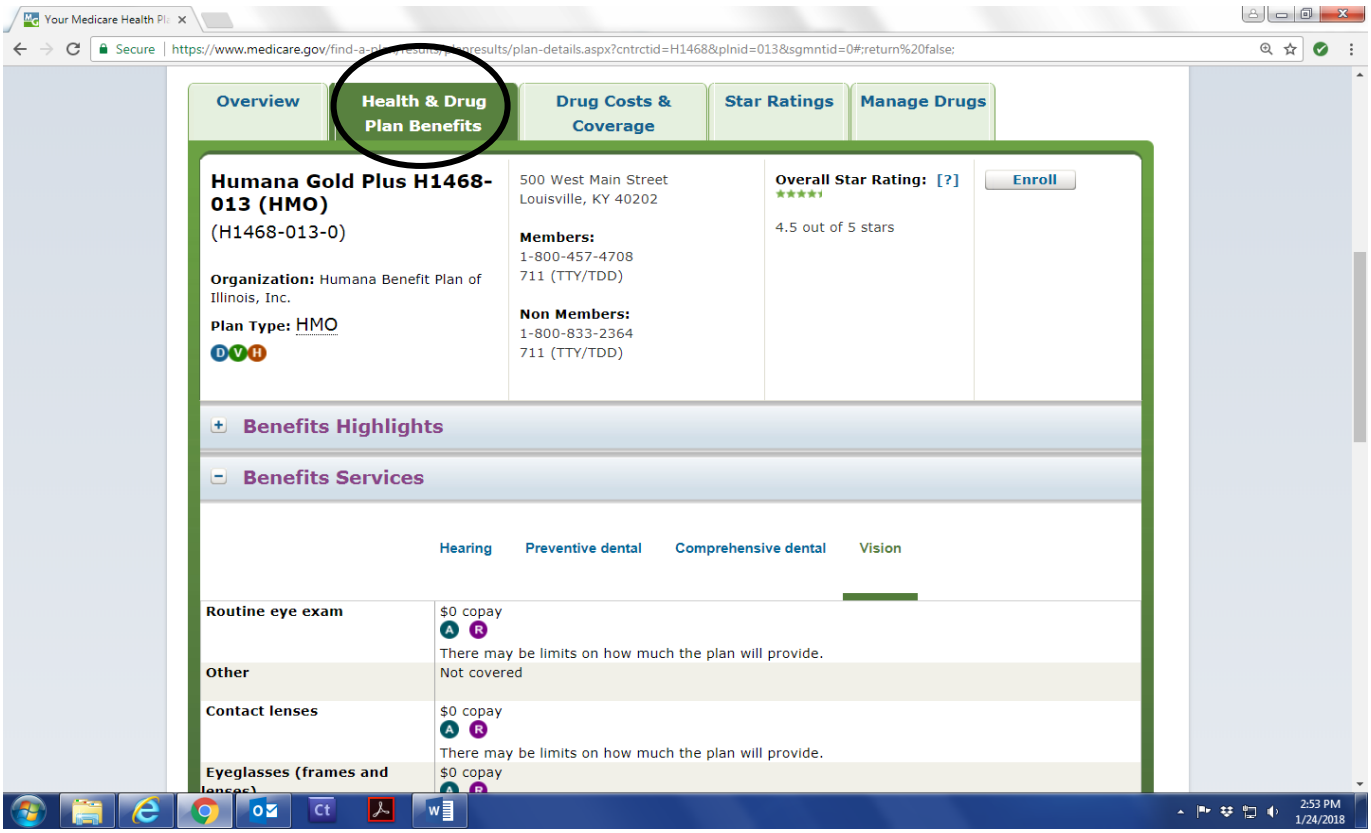
Medicare Advantage

Medicare Advantage (MA) plans are health plans offered by private insurance companies that are contracted and paid by Medicare to provide enrolled beneficiaries with inpatient, outpatient, and usually, prescription drug coverage. There are different types of MA plans, such as Medicare HMOs and PPOs, and each type of plan has its own set of rules. MA plans typically require beneficiaries to receive care from a list of providers that are in a plan's "network" for the service to be covered or for the beneficiary to pay less cost sharing.

Many MA health plans offer supplemental or "extra" benefits as part of their plan that may include dental, hearing and/or vision services such as hearing aids, eyeglasses, or routine

dental coverage. MA plans may choose what types of dental, vision, or hearing services to offer and whether coverage is routine, comprehensive, or not covered at all. In addition, the scope of services offered vary by plan, prior approval from the plan may be required, and depending on the type of MA plan, a referral from the beneficiary's primary care physician (PCP) may also be required. It is always important to consider a beneficiary's medical and prescription drug needs, the plan's provider network, and how much services cost with a plan before selecting a plan based on the extra benefits alone.

MA plans may offer vision services as a benefit of their health plan, although they are not required to do so by CMS. If an MA plan offers vision services, these services may be limited to routine eye exams, glasses, or contact lenses and up to a certain dollar amount every year. The range of services varies by plan. To determine if a plan offers vision services as a benefit, use the Medicare Plan Finder at www.Medicare.gov or call a plan directly. Plans that include vision benefits will display the following symbol: V and a description of which services are covered will be listed under the "Health & Drug Plan Benefits" tab when comparing plans. Please see below for a snapshot of where on the Medicare.gov Plan Finder extra vision benefits with an MA plan can be located.



Some MA plans may also contract with another insurer to offer their enrolled members an optional supplemental policy that includes additional vision coverage that is more comprehensive. Please note that supplemental policies may limit covered benefits to a specified annual dollar amount. These optional packages also vary by plan and may include dental, vision, or hearing coverage or all three under one policy. Optional benefit packages usually require the member to pay an extra premium each month in addition to the Medicare Advantage and Part B premium they already pay. Beneficiaries can find out if a plan offers these types of packages by contacting the plan directly or visiting the Medicare Plan Finder.

Medicaid (Fee-For-Service or FFS) in Illinois

Fee-for-service Medicaid in the State of Illinois provides vision and optical care for children and adults 21 and older and includes coverage for vision services and materials. According to the HFS Handbook for Providers of Medical Services, Medicaid covers "diagnosis and treatment of medical conditions of the eye and may be provided by an optometrist operating within the scope of his or her license" (see page 35). Medicaid covers eye exams, eyeglasses, eyeglass repairs, bifocal lenses, contact lenses, artificial eyes and low vision devices. There is a Medicaid co-pay of $3.90 for physician, clinic, and optometrists visits if the provider chooses to collect the copay from the patient.

The following services and items are covered by Medicaid:

- Vision exam once a year unless there is a documented medical need for additional exams
- Eyeglasses – one pair every two year period including frame parts, repairs or replacement for lost or broken glasses
- Contact lenses*
- Low vision devices*
- Artificial eyes; custom-made artificial eye*
- Polycarbonate eyeglass lenses for adults age 21 and older*
- Eyeglasses made by suppliers other than the Department of Corrections*
- Other optical services and supplies not identified by HFS*

Items and services marked with ***** require prior approval from HFS and may require documentation of medical necessity from the prescribing optometrist or physician. (See section O-211 of the HFS *Handbook for Providers of Optometric Services* for more information about services that require prior approval.)

Prescriptions by an optometrist or physician are required for eyeglasses and other eye care items and the provider must be enrolled in the Medicaid program in order for the service to be covered. Eyeglasses for adults that are covered through Medicaid are manufactured by the Department of Corrections and then supplied to participating optometrists and suppliers from which individuals can choose from. Medicaid does not pay for eyeglasses from another source other than the Department of Corrections unless HFS grants prior approval and an explanation from the prescriber detailing the reason. In addition, a new law effective August 18, 2017 will permit Medicaid to cover one additional pair of eyeglasses within the two year period for individuals who require a new pair of eyeglasses due to surgery (for ex., cataract surgery). Medicaid does not cover vision services that are not medically necessary, trifocals, or tinted lenses.

If prior approval for a service is denied by HFS, the individual has the right to appeal the denial as long as the appeal is filed within 60 days of receiving the denial notice. To file an appeal, beneficiaries can call the HFS Fair Hearing Section at 1-855-418-4421, fax an appeal to 1-312-793-2005, or mail a letter to HFS at: HFS, Bureau of Administrative Hearings 401 South Clinton Street, 6th floor Chicago, IL 60607.

For additional information on how Medicaid covers optical services and supplies, visit:

- HFS web page on medical provider handbooks and click on the "*HFS Handbook for Providers of Optometric Services"*
- Sections 140.416 and 140.417 of the administrative rules for HFS

Medicaid Managed Care Plans (MMAI and Health Choice Illinois plans)

Medicaid Managed Care plans are required to provide nearly all services offered under fee-for-service Medicaid. This includes optical services and items, in addition to optometrist services as part of the plan's health benefits package. Individuals usually need to visit a provider who is in the plan's network in order for the service to be covered by the plan. In addition, some types of vision services and items may require prior authorization from the plan. Medicaid managed care plans may also choose to offer extra vision benefits such as upgraded eyeglass frames or contact lenses. Plans may also contract with specific companies to administer the vision care portion of their health benefits package. Contact the managed care plan directly for more information or visit https://enrollhfs.illinois.gov/choose/compare-plans to compare Medicaid managed care plans.

Resources for Individuals without Vision Insurance or Coverage

Additional resources and services provided by charitable organizations may be available to individuals with limited incomes who are in need of eye care or eyeglasses. Eligibility criteria and benefits vary by program. Programs may provide vision exams, eyeglasses, or financial assistance for eye care and may require that individuals do not have insurance or coverage for vision care.

National Eye Institute (NEI)

The National Eye Institute is part of the federal government's National Institutes of Health and conducts and supports eye research. NEI does not provide direct financial assistance but does have a list of organizations, benefit programs, and charities that may provide financial assistance or vision care. To view a list of vision care resources, visit the National Eye Institute's website at https://nei.nih.gov/health/financialaid.

Illinois Eye Institute (IEI)

The Illinois Eye Institute is located in Chicago and provides vision care services. IEI accepts most forms of insurance, including Medicaid and Medicare. Individuals who do not have any vision insurance or are underinsured may qualify for discounted care through their Vision of Hope program. Individuals must meet financial criteria to qualify, and if approved, the cost for care ranges from $0- $40 per visit. (Fees are based on income and household size). For more information visit http://www.illinoiseyeinstitute.org/patient-information/insurance-and-vision-plans or call 3112-949-7234.

Living Well with Low Vision

Living Well with Low Vision is an organization that provides resources and information for individuals with vision loss. They also provide a list of agencies and organizations that can help with financial assistance for eye care. For more information visit http://lowvision.preventblindness.org/daily-living-2/financial-assistance-for-eye-care.

New Eyes for the Needy

New Eyes for the Needy provides prescription eyeglasses for people in need through a voucher program. To qualify, individuals must have a household income at or below 200% of the Federal Poverty Level, have had a recent eye exam, and have no insurance or resources that can pay for eyeglasses. New Eyes can help individuals locate resources and organizations that provide free or low-cost eye exams. Online applications must be

submitted by a social service agency on behalf of the client. The agency must register online at https://onlineapp.new-eyes.org/newrequest.jsp. For more information visit New Eyes at http://www.new-eyes.org.

Lions Club International
Lions Club International assists communities through local chapters by providing a number of programs and projects, including financial assistance for eye care through their Sight Program. Services include vision screenings, the purchase of eyeglasses, eyeglass fittings, and other health-related services. For more information and to find a local Lions Club, visit http://www.lionsclubs.org/EN/how-we-serve/assistance-requests.php.

Vision USA
The American Optometric Association (AOA) participates in the Vision USA program to provide free eye exams to individuals with limited incomes who do not have insurance or cannot afford the costs of eye care. Eligible individuals are referred to doctors in their area who volunteer with the Vision USA program. Individuals cannot apply on their own and must work with a social service or community health agency to submit an application. For more information or to obtain an application, visit http://www.aoafoundation.org/vision-usa.

EyeCare America
EyeCare America is a public service program of the Foundation of the American Academy of Ophthalmology and provides free eye exams to seniors 65 and older who qualify for the program. The program links eligible seniors with volunteer ophthalmologists to provide them a low-cost or free eye exam. To qualify, individuals must be 65 and older, a U.S. citizen or legal resident, not enrolled in an HMO or Medicare Advantage plan, not receiving eye care through the Veterans Administration, and not seen an ophthalmologist for three or more years. Please note that this program only provides eye exams, and in some instances follow up care, but does not provide eyeglasses. For more information, visit https://www.aao.org/eyecare-america.

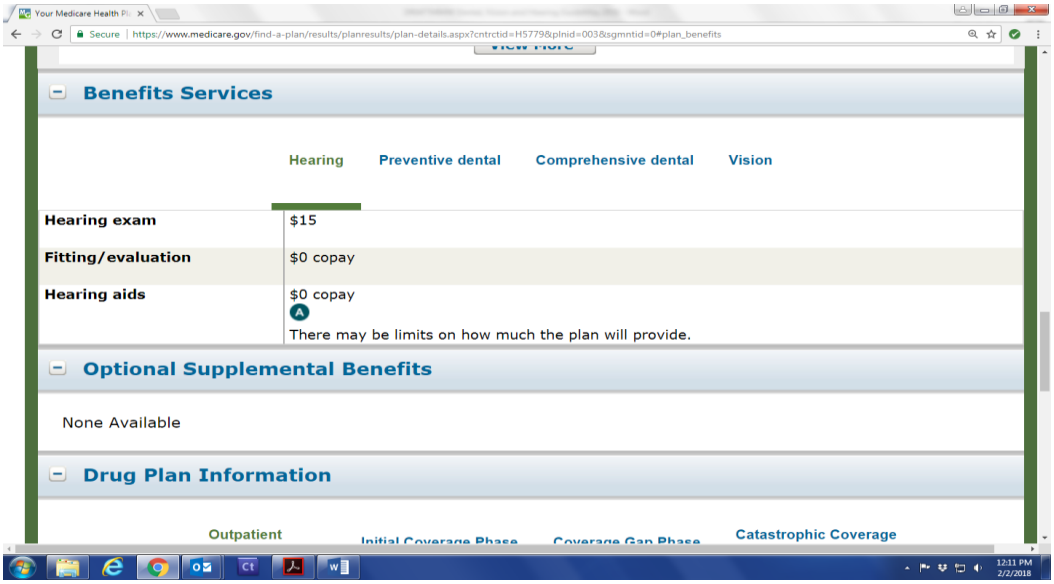
Hearing / Audiology Services

Original Medicare

Medicare does not cover routine hearing exams, hearing aids, or exams to fit hearing aids. The Social Security Act specifically excludes Medicare payment for hearing aids. Medicare Part B does cover diagnostic hearing and balance testing if ordered by a doctor to determine if a beneficiary is in need of medical treatment. Diagnostic tests must be performed by a qualified audiologist in order to be covered by Medicare. Medicare Part B cost sharing (20% of the Medicare-approved amount) applies to diagnostic hearing and balance exams once the annual Part B deductible is met. The beneficiary is also responsible for an outpatient hospital co-payment if the exam is done in an outpatient hospital setting. Diagnostic tests are not covered by Medicare when they are ordered specifically to fit or modify a hearing aid. Medicare also provides coverage for cochlear implants for beneficiaries who meet certain criteria found here. For more information on Medicare coverage of audiological services, visit Chapter 15 of the Medicare Benefit Policy Manual.

Medicare Advantage

Medicare Advantage (MA) health plans may provide coverage for audiological services and hearing aids, including routine hearing exams, hearing aids, and fittings for hearing aids. Please note, some MA plans may require prior authorization for hearing services and it is recommended that a beneficiary contact the MA plan directly or visit the Medicare Plan Finder to determine if a service has prior authorization (plans that require prior authorization will display the letter icon "A"). In addition, the types of hearing services that are covered and cost sharing amounts vary by plan. To view coverage details for MA plans, visit www.Medicare.gov and use the Medicare Plan Finder tool. MA plans that include hearing benefits display the following symbol on the Medicare Plan Finder: H. The snapshot below depicts where on the Medicare.gov Plan Finder extra benefits with an MA plan can be located.



Some MA plans may also contract with another insurer to offer their enrolled members an optional supplemental policy that provides coverage that is more comprehensive or to provide benefits up to a certain annual dollar amount. These optional packages also vary by plan and may include dental, vision, or hearing coverage or all three under one policy. Optional benefit packages usually require the member to pay an extra premium each month in addition to any Medicare Advantage and Part B premium they already pay. Beneficiaries can find out if a plan offers these types of packages by contacting the plan directly or visiting the Medicare Plan Finder.

Medicaid (Fee-For-Service)

Medicaid provides coverage for basic and advanced hearing tests, hearing aids, evaluation and counseling for hearing aids, fittings for hearing aids, hearing aid accessories, batteries, repairs and replacement parts. These services can be provided by a licensed audiologist that participates in Medicaid. Individuals may also use a participating durable medical equipment supplier to obtain hearing aids and hearing aid related items. A referral from a primary care physician, otologist, or otolaryngologist is required by Medicaid for audiologist's services. The Medicaid copay for medical visits is $3.90 if the provider chooses to collect it from the patient. To find a provider in your area that accepts Medicaid, contact the Health Benefits Hotline at (866) 468-7543.

Hearing aids are covered if medically necessary and the tests performed meet eligibility criteria. Medicaid covers binaural and/or monaural (one) or binaural (two) hearing aids (see section E-211.1 of the HFS Handbook for Audiology Services). Effective June 2014, prior approval by HFS is no longer required for binaural hearing aids unless a replacement is needed within three years of the initial hearing aid(s).

Hearing aid fittings and supplies (such as batteries, repairs, and replacements) are also covered. Note that hearing aid batteries for individuals with Medicaid in long-term care facilities are not covered through fee-for-service Medicaid since the costs are included in the payment made to the long-term facility.

For more information on Medicaid coverage of audiology services, click here to view the HFS Handbook for Providers of Audiology Services.

Medicaid Managed Care Plans (MMAI and Health Choice Illinois plans)

Medicaid Managed Care plans cover audiology/hearing services and hearing aids, but may require prior authorization from the plan for services and items. Individuals must usually receive care from a provider or medical equipment supplier that is in the plan's network in order for the service or item to be covered. Contact your managed care plan directly for more information on how a plan covers hearing aids and audiology services.

Resources for Individuals without Converge of Hearing Services

Charity and financial assistance programs may be available to help individuals obtain hearing exams, hearing aids and fittings. Visit the Illinois Deaf and Hard of Hearing Commission's website for a list of resources and hearing aid banks. Additional foundations and charities that may provide assistance with hearing aids and services include:

Lions Club International Foundation
The Lions Club provides reconditioned hearing aids to eligible individuals with limited incomes who do not qualify for Medicaid through their Lions Affordable Hearing Aid (AHAP) Project. Interested individuals must work with a local Lions Club chapter to apply for the program. Click here to find your local Lions club or contact Lions AHAP at (630) 203-3819.

Hearing AID Project
The Hearing Aid Project is a collaborative effort created by the Hearing Charities of America. The website allows individuals to search for hearing aid assistance and resources nationally and by state. Individuals who do not qualify for national or state assistance may qualify for assistance through the National Hearing Aid Project which provides hearing aids to individuals with low incomes. To qualify, individuals must have hearing loss that is documented by a licensed audiologist, have no insurance coverage for hearing aids, have a limited income, and be a U.S. resident. For more information, visit https://hearingaiddonations.org/get-an-aid.

Audient
Audient is a non-profit organization that helps individuals find hearing aids and services at lower costs through a network of hearing care providers. To qualify, applicants must have a household income up to 250% of the Federal Poverty Level. (In 2018, the 250% of the Federal Poverty Level for a household of 1 is $30,350.) To learn more about the program, visit http://www.audientalliance.org/index.php.

Hearing Loss Association of America (HLAA)
HLAA provides assistance and resources for people with hearing loss nationwide. The site provides a list of organizations that may provide assistance to purchase hearing aids and assistive devices. For more information on these listings, visit http://www.hearingloss.org/content/financial-assistance-programs-foundations

The Chicago Hearing Society
The Chicago Hearing Society is a non-profit agency that provides an array of programs and services for people who are Deaf, DeafBlind, or Hard of Hearing. The organization provides assistance in locating hearing services and operates a Hearing Clinic that provides hearing aid exams and hearing aid sales. For more information, visit http://www.chicagohearingsociety.org/index.php,

The Chicago Hearing Society also oversees a Hearing Aid Bank that provides new and reconditioned hearing aids for people in the Chicago metropolitan area who do not qualify for Medicaid or other public benefits. They also serve AARP members. Individuals are asked to complete an application to document their financial need. Qualified individuals are offered:

- Hearing evaluations
- Hearing aid consultations
- Hearing aid fittings
- Follow-up care

For more information call 773-248-9121 (voice) or 773-248-9174 (TTY) or visit http://www.chicagohearingsociety.org/audiology-clinic-a-hearing-aids/chicago-hearing-society-audiology-clinic-and-hearing-aid-service/hearing-aid-bank.

AARP Hearing Care Program

The AARP Hearing Care Program offers discounts to AARP members on hearing aids and hearing aids accessories. Members receive a 20% discount on hearing care and additional savings off of hearing aids. Please note that there is a small fee to become an AARP member. For more information, visit https://advantages.aarp.org/en/healthcare-insurance/hearing-care-program.html.

Illinois Telecommunication Access Corporation

The Illinois Telecommunication Access Corporation is a not-for-profit that provides free equipment such as amplified phones, captioned phones, cell phone amplifiers to the Deaf, Hard of Hearing, Late-Deafened, Deaf-Blind, and Speech-and Disabled communities. For more information visit http://www.itactty.org or call 800-841-6167.