SHIIP Combo Form

Seniors' Health Insurance Information Program
North Carolina Department of Insurance

1-800-443-9354
www.ncshiip.com

What is SHIIP?

Seniors' Health Insurance Information Program (SHIIP) is a consumer information division of the North Carolina Department of Insurance that assists people with Medicare, Medicare Part D, Medicare supplements, Medicare Advantage, and long-term care insurance questions. We also help citizens recognize and prevent Medicare billing errors and possible fraud and abuse through our NCSMP Program at 1-877-996-2767.

How does SHIIP work?

SHIIP provides education and assistance to North Carolinians in three ways:

- by operating a nationwide toll-free consumer information phone line Monday through Friday from 8 a.m. until 5 p.m.
- by training volunteers, including senior citizens, to counsel Medicare beneficiaries within their community about Medicare, Medicare Part D, Medicare supplements, Medicare Advantage and long-term care insurance, and
- by creating educational materials for consumers' use including the *Medicare Supplement Comparison Guide* and featuring a Medicare Supplement Premium Comparison Database on our Web site (www.ncshiip.com).

When was SHIIP started?

The program was founded in 1986 by the Department of Insurance in direct response to the growing concerns about health insurance for the more than one million Medicare beneficiaries in North Carolina. Numerous insurance companies sell Medicare supplements, Medicare Advantage, long-term care insurance and other medical insurance products to people in North Carolina. Because there are so many companies, and because the Medicare system is so complex, SHIIP was founded to provide people with Medicare an objective information service.

How do North Carolinians contact SHIIP?

You can contact SHIIP by dialing the nationwide toll-free consumer number, 1-800-443-9354, visiting the SHIIP Web site, www.ncshiip.com, or e-mailing ncshiip@ncdoi.gov. Trained SHIIP Volunteer Counselors are available in all 100 counties of North Carolina who are coordinated through an existing human service agency such as the Council on Aging or the Cooperative Extension offices. If your problem is too complex to handle over the phone, you will need to contact your local SHIIP Coordinator for a one-on-one appointment with a SHIIP Volunteer Counselor.

Can I get more information on SHIIP?

Yes! Contact SHIIP nationwide at **1-800-443-9354 or (919) 807-6900**, visit **www.ncshiip.com** or e-mail **ncshiip@ncdoi.gov** for further information and ask for more details on the Seniors' Health Insurance Information Program and how it can help you.

In ________________________ County, contact ____ at ____, phone number: ____________________________.

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2013 MEDICARE PART A:
HOSPITAL INSURANCE — COVERED SERVICES PER BENEFIT PERIOD

Services	Benefit	Medicare Pays (1)	You Pay (1)
HOSPITALIZATION Semi-private room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but **$1,184** deductible	**$1,184** deductible
	61st to 90th day	All but **$296** a day	**$296** a day
	91st to 150th day (2)	All but **$592** a day	**$592** a day
	Beyond 150 days	Nothing	All costs
POST-HOSPITAL SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days, enter a Medicare approved facility generally within 30 days after hospital discharge, and meet other program requirements. (3)	First 20 days	100% of approved amount	Nothing
	21st to 100th day	All but **$148** a day	Up to **$148** a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE (also see Part B) Medically necessary skilled care, home health aide services, medical supplies, etc. after a 3-day inpatient hospital stay for visits 1-100.	100% part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Full scope of pain relief and support services available to the terminally ill.	As long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first three pints per calendar year	For first three pints (4)

1) These figures are for 2012 and are subject to change each year.
2) Lifetime reserve days may be used only once.
3) Neither Medicare nor Medigap insurance will pay for most nursing home care.
4) To the extent the blood deductible is met under one part of Medicare during the calendar year it does not have to be met under the other part.

NOTE: The Medicare Part A premium is **$0** for eligible beneficiaries. For those who are ineligible the Medicare Part A premium is **$441** per month for those who worked fewer than 30 quarters or **$243** per month for those who worked between 30 and 40 quarters.

A **benefit period** begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 consecutive days.

2013 MEDICARE PART B:
MEDICAL INSURANCE - COVERED SERVICES PER CALENDAR YEAR

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSE Physicians' services, outpatient medical and surgical services and supplies, physical and speech therapy, diagnotic tests, durable medical equipment, ambulance services, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after **$147** deductible)	**$147** deductible (a) 20% of approved amount and charges above approved amount (b)
		65% of approved charges for most outpatient mental health services	35% of approved charges for mental health services
CLINICAL LABORATORY SERVICES	Blood tests, biopsies, urinalysis, etc.	Generally 100% of approved amount.	Nothing
HOME HEALTH CARE (also see Part A) Medically necessary skilled care, home health aide services, medical supplies, etc. after a 3-day inpatient hospital stay beginning with visit 101 or beginning day one if there is no previous hospital stay.	100% part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount	Nothing
		80% of approved amount for durable medical equipment	**$147** deductible (a) 20% of approved amount for durable medical equipment
OUTPATIENT HOSPITAL TREATMENT Reasonable and necessary services for the diagnosis or treatment of an illness or injury.	Unlimited if medically necessary	80% of approved amount (after **$147** deductible)	**$147** deductible (a) 20% of approved amount
BLOOD	Blood	80% of approved amount (after **$147** deductible and starting with the 4th pint)	**$147** deductible (a) First 3 pints plus 20% of approved amount for additional pints (c)

The monthly Part B premium for 2013 is $104.90

(Premiums will be higher for individuals with annual incomes of $85,000 or more and married couples with annual incomes of $170,000 or more.)

(a) Once you have paid **$147** for covered services the Part B deductible does not apply to any other covered service(s) you receive for the rest of the calendar year.
(b) The amount by which a physician's charge can exceed the Medicare approved amount is limited by law.
(c) To the extent the blood deductible is met under one part of Medicare during the calendar year it does not have to be met under the other part.

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STANDARDIZED MEDICARE SUPPLEMENT PLANS CHART

Plan A	Plan B	Plan C	Plan D	Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic benefits including 100% Part B coinsurance	Basic benefits including 100% Part B coinsurance except up to $20 copayment for office visit and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of pocket limit of $4,800; paid at 100% after limit reached	Out-of pocket limit of $2,400; paid at 100% after limit reached		

Basic Benefits

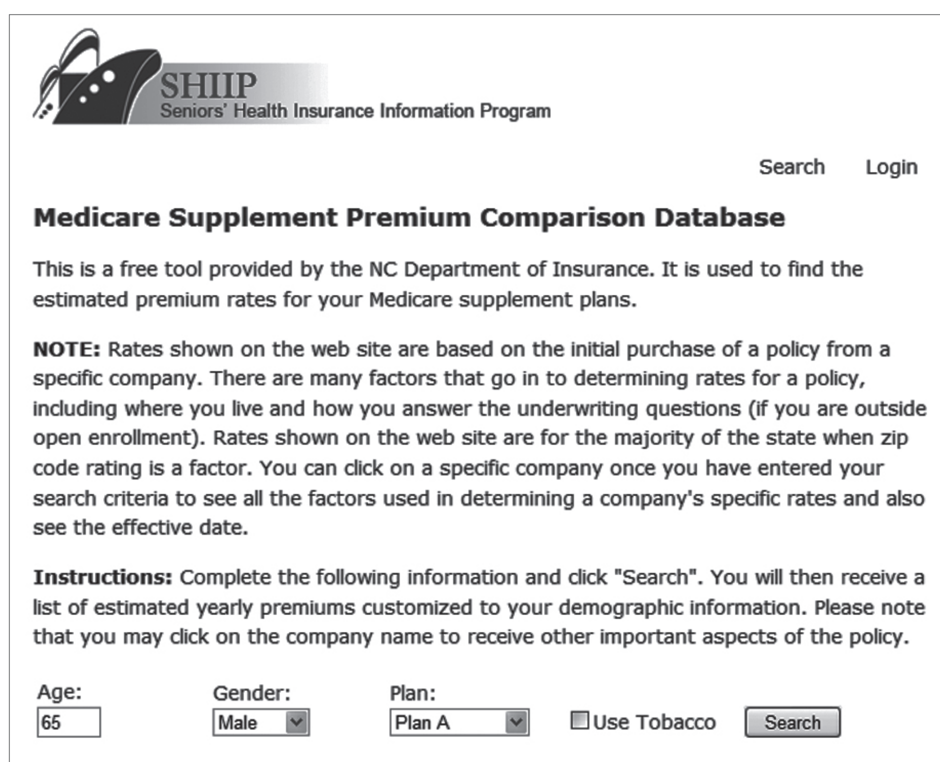
- Part A Hospital
  - 61-90 days — **$296**/day
  - 91-150 days — **$592**/day (lifetime reserve days)
  - Beyond 150 days — 100% for 365 days
- Parts A and B Blood Deductibles (1st three pints)
- Part B Coinsurance — 20% of Medicare approved charges
- Part A Hospice Care Coinsurance or Copayment

* F Prime has the same benefits but does not pay until you have met the $2,110 deductible.

Part A Deductible for 2013 is $1,184
Part B Deductible for 2013 is $147

Medicare Premium Supplement Comparison Database on the Web

SHIIP has an interactive tool on our Web site that allows individuals to compare Medicare supplement plans at the touch of their fingers. Below you will see a snapshot of how the page appears. By simply entering your age, gender, the Medicare supplement plan you want to compare and whether or not you smoke, the computer will generate a list of the companies offering that plan along with their estimated premiums. By clicking on the Company name you will be directed to other important aspects of the policy. This site has the most update to date information of plans available in North Carolina. It is located at http://www.ncdoi.com/medisupp/citizen/search.asp.



Medicare Advantage (Medicare Part C)

Medicare Advantage Plans are health care options provided under Medicare Part C of the Medicare program. These plans are approved by Medicare but operated by private companies. There are several plan options available under Medicare Advantage such as managed care plans that involve a provider network (HMOs and PPOs) to those that are specially designed for people with certain chronic diseases and other specialized health needs (SNPs) and some that may or may not have a provider network (PFFS) requirement. Some Medicare Advantage plans include Medicare prescription drug coverage but some do not.

To enroll in any Medicare Advantage plan option you must have both Medicare Part A and Medicare Part B. Once you enroll into a Medicare Advantage plan, you will not use your Original Medicare (red, white and blue) card as you no longer have Original Medicare. Instead the Medicare Advantage plan will provide you with a member ID card to use when visiting your medical provider. Please note, you will continue to pay the Medicare Part B premium, and you might also have to pay an additional monthly premium charged by the Medicare Advantage plan.

It is important to remember to check with your doctors and hospitals before making any change to your Medicare coverage to make sure they will accept the Medicare Advantage plan you are considering.

Medicare Preventive Benefits		
Covered Services	**Who is Covered**	**What You Pay**
One-Time Welcome to Medicare Preventive Visit and Yearly Wellness Visit One-time "Welcome to Medicare"preventive visit within twelve months of the day your Medicare Part B becomes effective. After you have had Part B for longer than 12 months you can get a "yearly wellness visit" to develop or update a prevention plan based on your current health and risk factors.	All people with Medicare.	You pay nothing for the "Welcome to Medicare" preventive visit or the yearly "Wellness" visit if the doctor accepts assignment. The Part B deductible does not apply; however, if your doctor performs additional tests or services during the same visit that aren't covered under these preventive benefits, you may have to pay coinsurance, and the Part B deductible may apply.
Colorectal Cancer Screening Fecal Occult Blood Test - Once every 12 months. Flexible Sigmoidoscopy - Once every 48 months. Screening Colonoscopy - Once every 10 years, but not within 48 months of a screening sigmoidoscopy if you are not at high risk for colon cancer. Once every 24 months if you are high risk for cancer of the colon. Barium Enema - Once every 48 months (or every 24 months if you are high risk) when used instead of sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older or at high risk for colorectal cancer, but there is no minimum age for having a screening colonoscopy.	You pay nothing for the fecal occult blood test. You pay nothing for the flexible sigmoidoscopy or screening colonoscopy if your doctor accepts assignment. However, if a screening test results in a biopsy or removal of a lesion or growth, the procedure is considered diagnostic and you may have to pay a copayment; however, the Part B deductible does not apply. For barium enemas you pay 20% of the Medicare-approved amount for the doctor's services. The Part B deductible does not apply. If it's done in a hospital outpatient setting, you pay a copayment.
Breast Cancer Screening (Mammogram) Once every 12 months for screening mammogram. Diagnostic mammogram covered when medically necessary.	All women with Medicare age 40 and older. Women can get one baseline mammogram between ages 35 and 39.	Screening Mammogram - You pay nothing for the test if the doctor accepts assignment. Diagnostic Mammogram - You pay 20% of the Medicare-approved amount.
Cervical and Vaginal Cancer Screening Pap test and pelvic exam to check for cervical and vaginal cancers once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer or if you are of childbearing age and have had an abnormal Pap in the past three years.	All women with Medicare.	You pay nothing for the lab Pap test, nothing for the Pap test specimen collection and nothing for the pelvic exam if the doctor accepts assignment.
Diabetes Screening, Supplies and Self-Management Training Coverage for glucose monitors, test strips, lancets and self-management training.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the annual Part B deductible.
Coverage for medical nutrition therapy services for beneficiaries with diabetes or kidney disease, including diagnostic therapy and counseling services furnished by a registered dietitian or nutrition professional.	Certain people with Medicare who have diabetes, kidney disease (not on dialysis) or had a kidney transplant within the last 3 years. Your doctor needs to refer you for this service.	20% of the Medicare-approved amount after the annual Part B deductible.
Up to two screening (Fasting Blood Glucose) tests a year for Medicare beneficiaries at risk for getting diabetes.	People with Medicare who are at risk for diabetes.	You pay nothing if your doctor or health care provider accepts assignment.
Prostate Cancer Screening Digital Rectal Exam – Once every 12 months. Prostate Specific Antigen (PSA) test - Once every 12 months.	All men with Medicare over age 50.	Digital Rectal Exam - 20% of the Medicare-approved amount after the annual Part B deductible. In a hospital outpatient setting you pay a copayment. PSA Test - You pay nothing for the test, and the Part B deductible does not apply.
Shots (Flu, Pneumococcal, Hepatitis B) Flu Shot - Once a year in the fall or winter. Pneumococcal (Pneumonia) Shot – One shot in a lifetime if your doctor deems necessary. Hepatitis B Shot (one series, three shots) - If you are at medium to high risk for hepatitis.	All people with Medicare.	Flu Shot - You pay nothing, and the Part B deductible does not apply. Pneumoccal and Hepatitis B Shots - You pay nothing if your doctor accepts assignment, and the Part B deductible does not apply.
Glaucoma Screening Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this test in your state.	People at high risk for glaucoma, including people with diabetes or a family history of glaucoma, African Americans age 50 and older, or Hispanic Americans age 65 or older.	20% of the Medicare-approved amount after the annual Part B deductible.
Cardiovascular Screening Screening blood tests for early detection of cardiovascular (heart) disease. Medicare covers screening tests for cholesterol, lipid and triglyceride levels every 5 years.	All people with Medicare.	You pay nothing for the test, and the Part B deductible does not apply. You pay 20% of the Medicare-approved amount for the doctor's visit.
HIV (Human Immunodeficiency Virus) Screening Once every 12 months, or up to 3 times during a pregnancy.	All people with Medicare.	You pay nothing for the test, but you generaly have to pay 20% of the Medicare-approved amount for your doctor's visit.
Bone Mass Measurements Once every 24 months for beneficiaries at risk for osteoporosis (more often if medically necessary).	Certain people with Medicare who are at risk for losing bone mass. Discuss with your doctor.	You pay nothing for this test if your doctor accepts assignment.

Medicare Part D: Prescription Drug Plan Benefit

The Medicare Prescription Drug Plans, also called PDPs, are provided by private companies that sell plans approved by Medicare. You can identify an approved plan by the MedicareRx logo. All people new to Medicare have a seven month window to enroll in a Medicare Part D drug plan – three months before, the month of, and three months after their Medicare becomes effective. Remember, the month you enroll will affect the month your PDP is effective.

All people with Medicare are eligible to enroll in a PDP, regardless of income or assets; however, unless they are new to Medicare or are entitled to a Special Enrollment Period, they must enroll during the Annual Election Period (AEP) which is October 15 through December 7. Options and features will vary from plan to plan such as drug lists with generic and brand name medications, drug prior approval requirements, and deductible and co-payment structures. You can only select one Medicare PDP. All of these differences will have a direct impact on the plan premium. Beneficiaries will want to compare plans and select the one plan that best meets their individual needs, such as, all your prescriptions are on the plan's list of covered drugs, you can use your preferred pharmacy, and the premium is affordable. For assistance in understanding and enrolling in a Medicare PDP, please refer to your current **Medicare & You Handbook**, which is published by the Centers for Medicare and Medicaid Services (CMS). Or you can visit the Medicare Web site at **www.Medicare.gov** or contact SHIIP at **1-800-443-9354**.

NOTE: If you do not enroll in a Medicare PDP when you become eligible and do not have creditable drug coverage in place, you will pay a penalty for life when you do enroll in a PDP during the AEP.

In North Carolina there are several approved companies offering PDPs. Some of the companies offer plans that have national coverage, which is especially important for beneficiaries who have residences in more than one state. Some plans are sold as stand-alone insurance products while others are offered through Medicare Advantage options such as HMOs, PPOs and Private-Fee-For Service (PFFS) plans. All plans may not be identical, but companies are required to offer benefits that are at least equal to Medicare's Standard PDP model of coverage outlined below.

There is assistance available for people with Medicare who have limited incomes and resources. If they qualify, they can receive assistance with premiums, deductibles and co-payments for their prescriptions. If someone has a monthly income of below **$1,396.25** as an individual or **$1,891.25** as a married couple living together and assets lower than **$13,300** as an individual or **$26,580** as a married couple living together (includes $1,500/person funeral or burial expense), they can visit their local Social Security office, call Social Security toll free at **1-800-772-1213**, visit **www.socialsecurity.gov**, or request an extra help assistance application by contacting SHIIP. People who qualify for any level of Medicaid automatically qualify for LIS and do not need to apply.

NOTE: If you applied for extra help and received a letter stating that you do not qualify for assistance, you are still eligible to enroll in a PDP but will be responsible for paying the premiums, deductibles and co-payments.

MEDICARE STANDARD PDP COVERAGE OUTLINE

All plans must at least provide the following benefits but may offer more:

2013 Basic/Standard Medicare Prescription Drug Plan Model

Actual Drug Costs	Medicare Pays	Beneficiary Pays	Cumulative Beneficiary Out-of-Pocket Total
$0 - $325	$0	$325 (drug deductible)	$325
$325.01 - $2,970	$1,983.75 (75%)	$661.25 (25%)	$986.25 ($325+$661.25)
$2,970.01 - $6,733.75	$0	$3,763.75 *	$4,750 ($986.25+$3,763.75)
$6,733.76 +	about 95%	about 5%	varies

Some Medicare prescription drug plans may have additional options to help pay for out-of-pocket costs.

***Once you reach the coverage gap you receive a 50% discount on brand name prescription drugs covered on your plan's formulary. The entire price of the drug (including the 50% discount the drug company pays) will count toward the amount you need to qualify for catastrophic coverage.**

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Seniors' Health insurance Information Program (SHIIP)
Health Expense Payment Record

Explanation of Benefits

Provider: ______________________________

1-800-443-9354
www.ncshiip.com
shiip@ncdoi.gov

Medical Services		Medicare Summary Notice (MSN)					Insurance			Amount Paid by Patient & Date	Total Paid to the Provider	Patient Owes
Date of Service	Actual Charge	Date of MSN	Medicare Assignment Accepted?	Medicare Approved Amount	Medicare Payment	Total You May Be Billed	Filed	Date of Payment	Amount Paid			