



SHIIP Combo Form

Seniors' Health Insurance Information Program
North Carolina Department of Insurance
Jim Long, Commissioner

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.

How does SHIIP work?

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

- by operating a 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 Comparison Database on our Web site (www.ncshiip.com).

When was SHIIP started?

The program was founded in 1986 by Insurance Commissioner Jim Long in direct response to the growing concerns about health insurance for the more than one million Medicare beneficiaries in North Carolina. More than 100 different 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, Commissioner Long felt there needed to be an objective information service for people with Medicare, so he founded SHIIP.

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 shiip@ncdoi.net. 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 **shiip@ncdoi.net** 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: _____.

Raleigh, NC • 919-807-6900 • 1-800-443-9354 • www.ncshiip.com

2008 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 \$1,024 deductible	\$1,024 deductible
	61st to 90th day	All but \$256 a day	\$256 a day
	91st to 150th day (2)	All but \$512 a day	\$512 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 \$128 a day	Up to \$128 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 2008 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 \$423 per month for those who worked fewer than 30 credits or \$233 per month for those who worked between 30 and 40 credits.

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.

2008 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, diagnostic tests, durable medical equipment, ambulance services, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after \$135 deductible) 50% of approved charges for most outpatient mental health services	\$135 deductible (a) 20% of approved amount and charges above approved amount (b) 50% 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
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 for durable medical equipment	\$135 deductible (a) 20% of approved amount for durable medical equipment
BLOOD	Blood	80% of approved amount (after \$135 deductible) 80% of approved amount (after \$135 deductible and starting with the 4th pint)	\$135 deductible (a) 20% of approved amount \$135 deductible (a) First 3 pints plus 20% of approved amount for additional pints (c)

The monthly Part B premium for 2008 is \$96.40

(Premiums will be higher for individuals with annual incomes of \$82,000 or more and married couples with annual incomes of \$164,000 or more.)

- (a) Once you have paid \$135 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.

STANDARDIZED MEDICARE SUPPLEMENT PLANS CHART

Plan A	Plan B	Plan C	Plan D	Plan E	Plan F or Plan F Prime with \$1,900 Deductible	Plan G	Plan H	Plan I	Plan J or Plan J Prime with \$1,900 Deductible
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)	Part B Excess (100%)	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	Foreign Travel Emergency	Foreign Travel Emergency At-Home Recovery Preventive Care

Basic Benefits

- Part A Hospital Days
- 61-90 - **\$256/day**
- 91-150 - **\$512/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 Deductible for 2008 is \$1,024

Part B Deductible for 2008 is \$135

“A” - “L”

Insurance companies are not permitted to change the letter designations A-L or to substitute other names or titles. However, they may add names or titles to these letters. Please note Plans K & L are described on the following page.

Medicare Supplement Plans K and L

There are several companies marketing the Medicare Supplement Plans K and L. These plans require cost sharing for part A and Part B expenses at **50%** and **75%**, respectively. Plan K has a **\$4,440** out-of-pocket limit while Plan L has a **\$2,220** out-of-pocket limit annually. The plans exclude the Part B deductible and the reasonable cost of the first three pints of blood. Once you reach the annual limit, the plan pays 100 percent of the Medicare copayments, coinsurance and deductibles for the remainder of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare approved amounts (excess charges). You will be responsible for paying excess charges. Since cost sharing is higher under these plans, the premiums may be more cost effective than traditional plans. The annual out-of-pocket limit increases each year for inflation.

Benefit	Plan K	Plan L
Hospitalization	100% of Part A hospitalization coinsurance 61st to 90th day - \$256 90st to 150th day - \$512 Coverage for 365 days after Medicare Benefits end (Lifetime Reserve Days)	100% of Part A hospitalization coinsurance 61st to 90th day - \$256 91st to 150th day - \$512 Coverage for 365 days after Medicare Benefits end (Lifetime Reserve Days)
Part A Deductible	50% of \$1,024 (per benefit period)	75% of \$1,024 (per benefit period)
Post-Hospital Skilled Nursing Facility Care	50% of \$128 (per day) (for days 21 through 100)	75% of \$128 (per day) (for days 21 through 100)
Hospice	50% of cost sharing	75% of cost sharing
Blood	50% of Medicare eligible expenses for first three pints	75% of Medicare eligible expenses for first three pints
Part B Coinsurance	50% (after Part B deductible met) 100% coinsurance for preventive services only.	75% (after Part B deductible met) 100% coinsurance for preventive services only
Out-of-Pocket Annual Limit	\$4,440	\$2,220

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 do not have a provider network (PFFS) requirement. There is even a plan option that is a combination of a Medicare Advantage and Medical Savings Account (MSAs) where Medicare deposits money that you may use to pay health care costs. Some Medicare Advantage plans include Medicare prescription drug coverage but many do not.

In order 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 continue to 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 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

Revised 7/08

Covered Services	Who is Covered	What You Pay
<p><u>Bone Mass Measurements</u> Once every 24 months for beneficiaries at risk for osteoporosis (more often if medically necessary).</p>	Certain people with Medicare who are at risk for losing bone mass. Discuss with your doctor.	20% of the Medicare approved amount (or a set copayment amount) after the annual Part B deductible.
<p><u>Colorectal Cancer Screening</u> Fecal Occult Blood Test - Once every 12 months. Flexible Sigmoidoscopy - Once every 48 months. 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 - Doctor can substitute for sigmoidoscopy or colonoscopy.</p>	All people with Medicare age 50 and older or at high risk for colorectal cancer. However, there is no minimum age for having a colonoscopy.	Nothing for the fecal occult blood test. For all other tests 20% of the Medicare approved amount. For flexible sigmoidoscopy or colonoscopy you pay 25% of the Medicare-approved amount if the test is done in an ambulatory surgical center or hospital out-patient department.
<p><u>Mammogram Screening</u> Once every 12 months. Medicare also covers new digital technologies for mammogram screenings.</p>	All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.	20% of the Medicare-approved amount with no Part B deductible.
<p><u>Pap Test and Pelvic Examination</u> (Includes a clinical breast exam) 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 smear in the preceding three years.</p>	All women with Medicare.	Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams 20% of the Medicare-approved amount (or a set copayment amount) with no Part B deductible.
<p><u>Diabetes Services</u> Coverage for glucose monitors, test strips, lancets and self-management training. Coverage for medical nutrition therapy services for beneficiaries with diabetes or renal disease, including diagnostic therapy and counseling services furnished by a registered dietitian or nutrition professional. Up to two screening tests a year for Medicare beneficiaries at high risk of getting diabetes, including fasting plasma glucose test.</p>	<p>All people with Medicare who have diabetes (insulin users and non-users).</p> <p>Certain people with Medicare who are at risk for complications from diabetes, if requested by your doctor or provider.</p> <p>People with Medicare who are at risk for diabetes.</p>	<p>20% of the Medicare-approved amount after the annual Part B deductible.</p> <p>20% of the Medicare-approved amount after the annual Part B deductible.</p> <p>No coinsurance or Part B deductible for diabetes screening lab test. For all other tests 20% of the Medicare-approved amount after the annual Part B deductible.</p>
<p><u>Prostate Cancer Screening</u> Digital Rectal Examination – Once every 12 months. Prostate Specific Antigen (PSA) test - Once every 12 months.</p>	All men with Medicare age 50 and older.	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the Part B deductible. No coinsurance and no Part B deductible for the PSA test.
<p><u>Shots (Vaccinations):</u> Flu Shot - Once a year in the fall or winter. Pneumococcal Pneumonia Shot – One shot may be all you will ever need. Ask your doctor. Hepatitis B Shot (one series, three shots) - If you are at medium to high risk for hepatitis.</p>	All people with Medicare.	Nothing for flu and pneumococcal shots if the health care provider accepts assignment. For Hepatitis B shots 20% of the Medicare-approved amount (or set copayment amount) after the annual Part B deductible.
<p><u>Glaucoma Screening</u> Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to render this service in your state.</p>	People at high risk for glaucoma, including people with diabetes or a history of glaucoma, or African Americans age 50 and older.	20% of the Medicare-approved amount after the annual Part B deductible.
<p><u>Cardiovascular Screening</u> Screening blood tests for early detection of cardiovascular (heart) disease. Medicare covers screening tests for cholesterol, lipid and triglyceride levels every 5 years.</p>	All people with Medicare.	No coinsurance or Part B deductible for lab test. For all other tests 20% of the Medicare-approved amount after the annual Part B deductible.
<p><u>Welcome to Medicare Physical (IPPE)</u> One-time wellness physical exam within six months of the day your Medicare Part B becomes effective.</p>	All people with Medicare.	20% of the Medicare-approved amount after the annual Part B deductible.
<p><u>Abdominal Aortic Aneurysm (AAA)</u> Ultrasound screening.</p>	Medicare beneficiaries with certain risk factors for AAA. Important – Eligible beneficiaries must receive a referral for ultrasound screening for AAA as a result of their Welcome to Medicare Physical (IPPE).	20% of the Medicare-approved amount with no Part B deductible.

Medicare Part D: Prescription Drug Plan Benefit



The Medicare Prescription Drug Plans are provided by private companies that sell plans approved by Medicare. These plans are called Medicare Prescription Drug Plans or PDPs. 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 which is November 15 through December 31. 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 coverage 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**.

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 an annual income of below **\$15,600** as an individual or **\$21,000** as a married couple living together and assets lower than **\$11,990** as an individual or **\$23,970** 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.

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 have the responsibility to pay the premiums, deductibles and co-payments.

In October 2006 Governor Easley announced a new State Pharmacy Assistance Program called NCRx that works with Medicare prescription drug coverage. A Medicare beneficiary may qualify for this assistance if they are a resident of North Carolina and meet other requirements (such as limited income and resources, not eligible for the full federal Extra Help" subsidy, etc.). For more information or to obtain an application, visit the Web site at www.ncrx.gov or call NCRx at **1-888-488-6279**.

MEDICARE'S STANDARD PDP COVERAGE OUTLINE

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

2008 Basic/Standard Medicare Prescription Drug Plan Model

Actual Drug Costs	Medicare Pays	Beneficiary Pays	Cumulative Beneficiary Out-of-Pocket Total
\$0 - \$275	\$0	\$275 (drug deductible)	\$275
\$275.01 - \$2,510	\$1,676.25 (75%)	\$558.75 (25%)	\$833.75 (\$275+\$558.75)
\$2,510.01 - \$5,726.25	\$0	\$3,216.25 (100%)	\$4,050 (\$833.75+\$3,216.25)
\$5,726.26 +	about 95%	about 5%	varies

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

